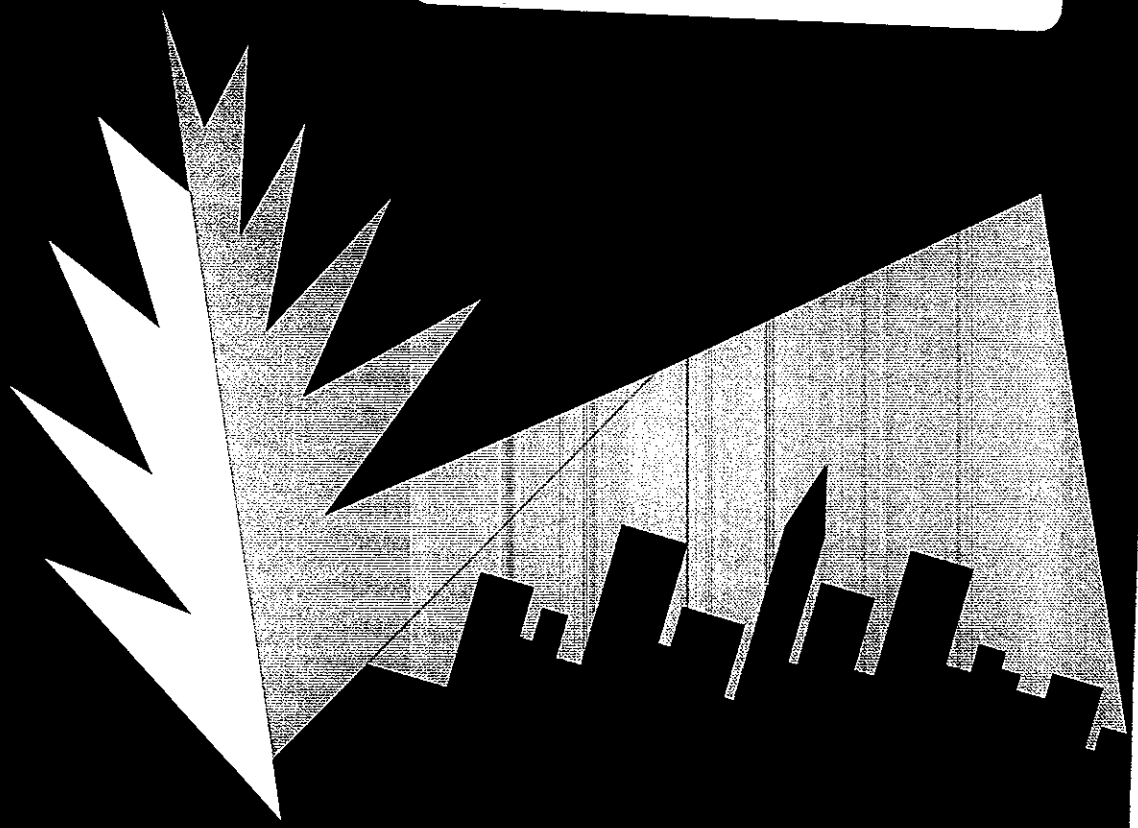
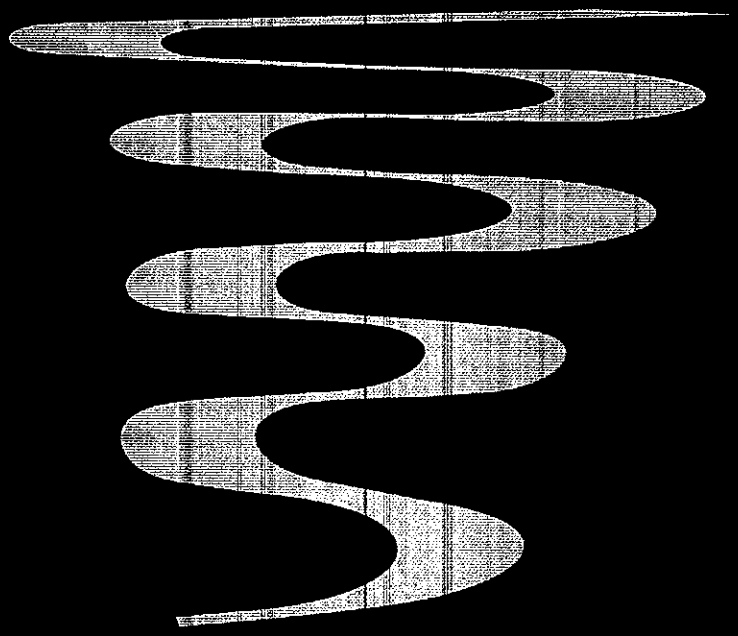
Global
Health
Council





30th Annual Conference

Our Future on Common Ground: Health and the Environment

Final Program

27-30 May, 2003 Washington, D.C.

"...When it comes to global health, there is no *them*, only *us*."

www.globalhealth.org

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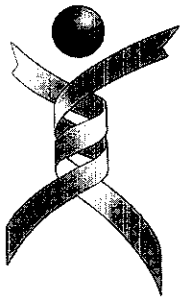

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Global Health Council, in presenting its 30th Annual Conference, is sponsoring scientific sessions to discuss issues of concern to individuals working in the field of public health. The Council uses reasonable efforts to provide a balanced presentation of issues in an atmosphere of civility but the Council is not responsible for the views presented or discussions that occur. The views presented in the Annual Conference scientific sessions and on Conference video, audiotapes, publications, etc. are those of the presenters and not necessarily those of the Council.

B

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Conference Acknowledgments

The Global Health Council wishes to thank the following organizations for their provision of core funding support for this conference:

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SPECIAL THANKS TO NANCY HARRIS, THE STAFF AT JSI-MADAGASCAR AND UNICEF FOR THEIR INVALUABLE ASSISTANCE RELATED TO THE VISIT OF PRESIDENT MARC RAVALOMANANA OF MADAGASCAR.

The Global Health Council is grateful to all the speakers and special guests participating in this year's program and Awards Banquet. All of them have generously donated their time to appear at the conference.

Finally, we are grateful to those who generously assisted with program development for this year's conference:

Sohail Agha
Milton B. Amayun
David Brooks Arnold
Franklin Baer
Robert E. Black
John Borrazzo
A. David Brandling-Bennett
Jerry Coovadia
Reenal Doshi
Robert Emrey
Mary Lyn Field-Nguer
Glenn W. Geelhoed
Mita Sengupta Gibson
Aparajita Gogoi
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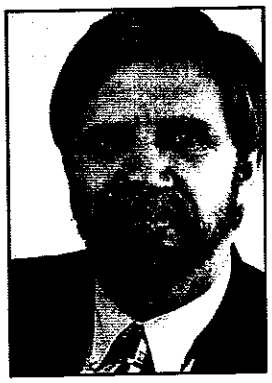
Patricia A. Taylor
Joseph J. Vitale
Jimmy Volmink
Richard D. Waddell
Ronald Waldman
Stephanie Wilcock
Scott Wittet
Marisha Wojciechowska
Sara Woldehanna
Nancy Yinger
Soon-Young Yoon
Gordon Youngman
Pamela A. Zeiser

Welcome

Dear Colleagues:

Welcome to the Global Health Council's 30th Annual Conference.



We are pleased to be celebrating this anniversary with conference participants from more than 60 nations, who have joined us this week to discuss *Our Future on Common Ground: Health and the Environment.* Together we will explore the relationship between our health and our surroundings, and inform ourselves of the vast implications that changes to our physical, social and economic environments hold for the health of the world.

Over the course of these past three decades, the international community has started to come to grips with the environmental consequences of our increasingly global society. Progress has been made in the fight to protect the natural resources upon which our health – indeed our very lives – depend.

And yet longstanding problems still persist, while new ones arise continuously: this is the fundamental nature of the dynamic interface between the environment and human health. Climate change that threatens the food supply is exacerbating malnutrition. High fertility levels and growing population pressures contribute to deforestation and desertification. Harmful chemicals now pervade many poor communities, which have increasingly become the toxic dumpsites of the world. Antibiotics pervade contaminated water, and lack of clean water and clear air could affect the health of hundreds of millions. And persistent social and economic inequities – often fueled by the dynamics of globalization – are widening the health gap between the world's richest and its poorest citizens.

This week we will seek to better understand this interface, to explore concrete ways in which the health community can thoughtfully incorporate environmental considerations into our daily work. By bringing together an extraordinary cadre of experts from the fields of public health and the environment, we seek to move this fluid boundary closer to our vision of a healthy world.

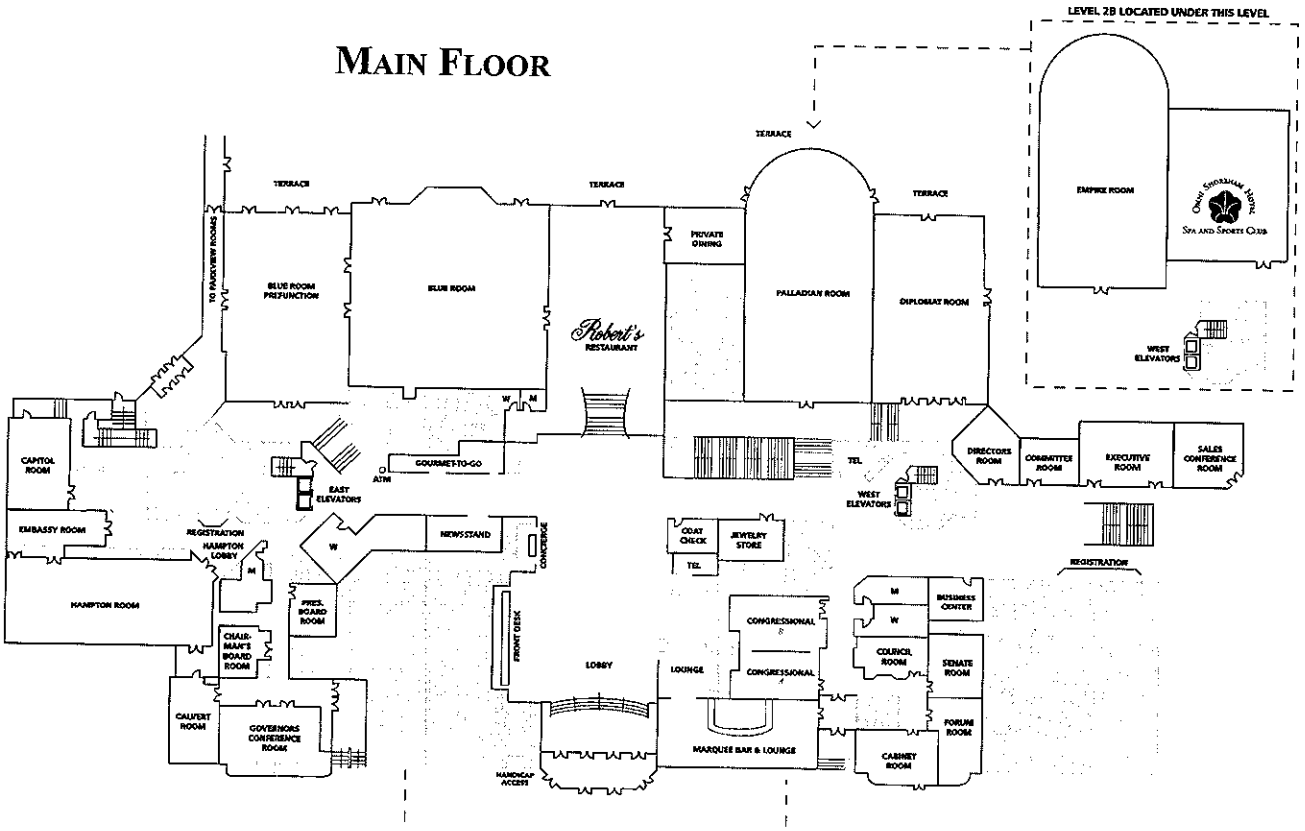
In doing so, we will be finding more than one expanse of common ground. This week we will not only advance our understanding of the relationship between health and the environment, but the common fight that environmental activists and advocates for better health must wage together. This is necessary to multiply our impact, from the corridors of power to the alleyways of the world's poorest slums. Ecology teaches us that there is great strength in common purpose and common understanding. By developing relationships that reach across traditional areas of expertise, we will harness that power.

I look forward to joining you this week for a vital exchange of insights and experience. From understanding comes meaningful action. From this action we will work to create the world we envision.

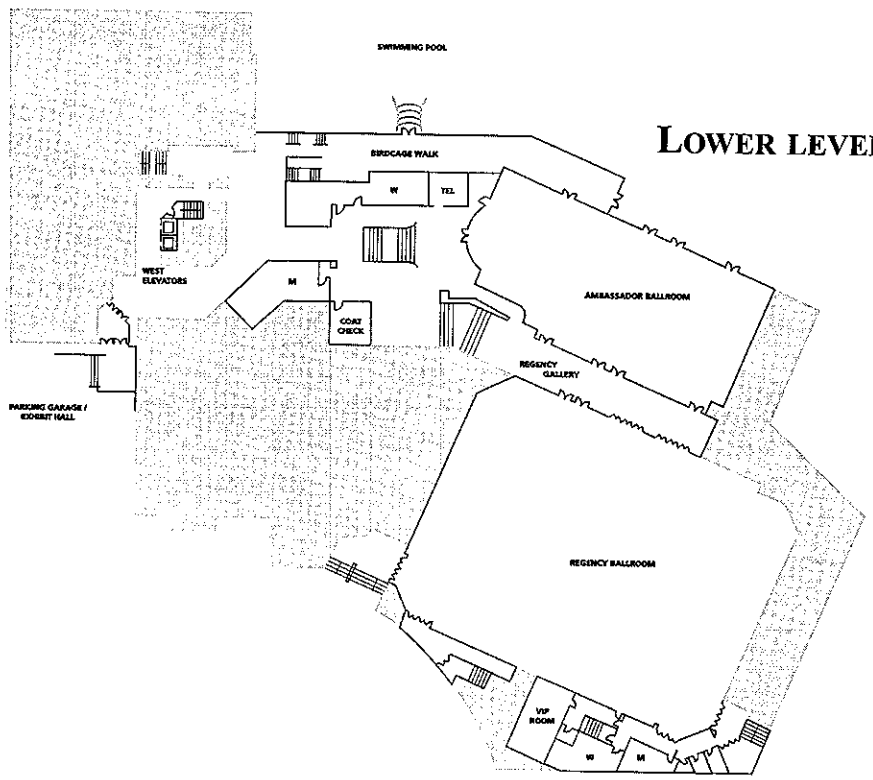
Nils Daulaire
President and CEO
Global Health Council

Omni Shoreham Hotel

MAIN FLOOR



LOWER LEVEL



General Information

Welcome to the Global Health Council's 30th Annual Conference. The staffs of the Global Health Council and the Omni Shoreham Hotel look forward to hosting you over the next several days. We value your comments and suggestions, so please stop by the Conference Registration Desk and let us know how we are doing and how we might better assist you during the conference.

Bookstore
We encourage you to visit the Annual Conference Bookstore, located in the Exhibition Hall at Booth 401, to browse and purchase books authored, or recommended by, conference presenters.

Business Center
Photocopying, computers, fax machines and other business services are available at the Omni Shoreham Business Center, located on the main lobby level near the Conference Registration Area. It is open from 7 am until 7 pm, Monday–Friday.

Checkout
Checkout time from the Omni Shoreham is noon. For faster service, use the in-room video checkout system on your television. Please see the staff at the hotel's bell stand if you would like to store any luggage.

CyberCafe
For the convenience of our participants, a CyberCafe is available during the conference. Located in the Exhibition Hall, the Café will feature internet-connected computers allowing participants to check their e-mail or browse the websites of our exhibitors. In addition, there will be several ethernet connection points to allow laptop connections to the internet. Technical staff will be available to assist with any questions. The CyberCafe will be open May 28–30, during the same hours as the Exhibition Hall.

Continuing Medical Education Credits
If you would like to receive continuing medical education credits for your attendance at the Annual Conference, please register with the Onsite Registration staff in the Conference Registration Area. You will receive instructions and an evaluation packet upon registration. The cost for continuing education registration is $65, payable upon registration. You must register prior to attending sessions.

International Exhibition Hours
Wednesday, May 28— 8 am–2 pm, 5:30–7 pm
Thursday, May 29—8 am–2 pm, 5–6:30 pm
Friday, May 30—8–11 am

Locations for Conference Events
May 27, Advocacy Day (Congressional Luncheon & Hill Visits): Hart Senate Office Building on Capitol Hill
All other conference events May 27–30 will be held at the Omni Shoreham Hotel.

Meals at the Conference
The following meals are offered at the conference:
- Continental Breakfast —May 28–30 in the Exhibition Hall
- Dinner — May 28 (Members Only dinner meeting), May 29 Awards Banquet (pre-registration and ticket required)
- The Council will host a reception in the Exhibition Hall on the evenings of May 28 and May 29. Additional receptions and events are hosted by our member, sponsor and partner organizations; please refer to the program description listings for schedule of events.

Dining On Your Own
- The Omni Shoreham features Robert's Restaurant as its main dining room, which is open daily for Breakfast, Lunch & Dinner from 6:30 am–10:30 pm.
- A Little Something Gourmet-To Go, located in the East Wing Corridor, features coffee, sandwiches and light snacks.
- For your convenience, a concession area featuring lunch and snack items will be available in the Exhibition Hall May 28 and 29, mid-morning to late afternoon. On Friday, May 30, the concession area will be moved to the Diplomat Foyer.
- Room Service—24-hour in-room dining is available to Omni guests.

In addition, there are many inexpensive ethnic restaurants & shops within easy walking distance of the Omni Shoreham.

Messages and Faxes
If you are staying at the Omni Shoreham Hotel, your telephone messages will go directly to your room. Any messages that come to the conference staff will be posted on the message bulletin board located in the Conference Registration Area.

Name Badges
Please wear your name badge at all times during the conference, as they are required for entry to all activities. Badges are issued to the individual registered and may not be used by others. There is a $10 replacement charge for lost badges.

Newspapers—Stay in touch with the news at home!
International newspapers are now available to download from a special kiosk located near the entrance to the West Registration Desk area. In addition, newspapers, magazines, books, gifts and other sundries are available in the Omni's newsstand & shop, located just off the main lobby, past the Concierge Desk.

Recycling
Recycling bins for mixed paper and beverage cans and bottles will be placed in various locations throughout the conference function areas for your convenience. Please join us in reducing our conference waste by placing the above items in the proper receptacles.

Safety and Security
Please do not leave your belongings or conference materials unattended in session rooms. Please be advised that for security reasons the Global Health Council is unable to hold any items for you. Luggage may be stored at the hotel's bell stand. Please check the Conference Registration Desk or the Hotel Concierge for lost and found items.

Speaker Ready Room
A Speaker Ready Room will be located in the Committee Room, across from the Conference Registration Area, for those presenters who would like an opportunity to review or practice their presentations. A laptop computer and LCD projector for viewing PowerPoint presentations and an overhead projector and screen will be available. If you prefer, you can use your own laptop computer to practice.

The Speaker Ready Room is available during the following dates and times:
- Tuesday, May 27, 7 am–5 pm,
- Wednesday, May 28, 7:30 am–5 pm
- Thursday, May 29, 7:30 am–5 pm,
- Friday, May 30, 7:30 am–1:30 pm.

The room will be locked but the key will be readily available from the Onsite Conference Registration Desk staff.

Transportation
Motor coach transportation from the Omni Shoreham is available for the following off-site event:
May 27, Advocacy Day: Congressional Luncheon & Hill Visits Only—Departure at 11:30 am from the Omni's Parkview Entrance in the East Wing of the hotel. One-way transportation; participants are responsible for return trip transportation.

On Your Own—The Woodley Park-Zoo *(Red Line) Metro* stop is a short walk from the Omni. Taxi, limousine and shuttle services are available via the hotel concierge. Stop by the Concierge Desk, or call extension 16.

Conference at a Glance

Please see pages 19-49 for a complete program description, including special sessions and receptions.

Monday, May 26, 2003

4 - 8 pm	Registration Open *Omni Shoreham Hotel* - West Registration Desk

Tuesday, May 27, 2003

7 am - 5 pm	Registration Open *Omni Shoreham Hotel* - West Registration Desk

Advocacy Day Events

8-9 am	Check-in *Room locations assigned upon check-in*
9-11:30 am	Advocating for Global Health Training Sessions *Omni Shoreham Hotel*
11:30 am - Noon	Transportation departs for Advocacy Day participants from *Omni's Parkview Entrance - East Corridor off Main Lobby*
Noon - 2 pm	Congressional Luncheon on Capitol Hill - *Hart Senate Office Building, Room 902*
2:30 - 4 pm	Congressional Hill Visits

9 am - Noon	Skill-Building Workshops: *Omni Shoreham Hotel*
	W1: Delivering Winning Presentations - Empire Ballroom
	W2: A Modern Paradigm for Improving Health Care Quality - Executive Room
	W3: Developing an Expanded and Comprehensive Response to the HIV/AIDS Epidemic - Congressional Room B
	W4: Using Best Practices to Improve Program Performance - Cabinet Room
	W5: Using Research Evidence to Improve Health: Understanding and Interpreting Systematic Reviews - Congressional Room A
1 - 4 pm	Skill-Building Workshops: *Omni Shoreham Hotel*
	W6: Geographical Information Systems (GIS) in Public Health: Getting Started - Cabinet Room
	W7: Measuring Morbidity and Mortality Rates in Emergency Surveys - Congressional Room B
	W8: Preparing to Deliver Care and Treatment to People with HIV/AIDS - Executive Room
	W9: How to Strengthen Pre-service Education Systems - Congressional Room A

Wednesday, May 28, 2003

7 - 8:30 am	Continental Breakfast in Exhibition Hall
7:30 am - 5 pm	Registration Open - West Registration Desk
7:30 - 8:30 am	Career Connection Breakfast Session: How to Network at the Conference, Interviewing Skills - Congressional Rooms A/B
9 - 10:30 am	Plenary Session - Making the Connections: Linkages Between Health and the Environment - Regency Ballroom
10:30 - 11 am	Coffee Break in Exhibition Hall
11 am - 12:30 pm	Concurrent Sessions - A Series
	A1: People Power: Strategies for Improvement among Health-Care Workers - Congressional Rooms A/B
A	A2: Knowing to Caring: VCT, MTCT and Home-Based Care - Regency Ballroom
	A3: It's Back: The Return of Vector Control as a Tool Against Malaria - Executive Room
	A4: Gender Inequity and Violence: Challenges in the Social Environment - Ambassador Ballroom
	A5: Toxic Exposure: Combating Risk in Urban and Agricultural Settings - Cabinet Room
	A6: The Special Vulnerabilities of Children to Environmental Conditions - Palladian Ballroom
	A7: Health Sector Reform and Financing: Resources and Expenditures - Governor's Room
12:30 - 2 pm	Lunch Break
12:45 - 1:45 pm	Demonstration: Using the Arts in Health Interventions - Palladian Ballroom
2 - 3:30 pm	Concurrent Sessions - B Series
	B1: Supply and Demand: Addressing Challenges in Health Service Delivery - Palladian Ballroom
B	B2: In the Face of Famine: Increasing Food Security in Sub-Saharan Africa - Governor's Room
	B3: Taking Child Health Services to Scale - Executive Room
	B4: The Persistence of Inequity: Current Trends in Reproductive Health - Regency Ballroom
	B5: Community Participation for Youth Reproductive and Sexual Health - Ambassador Ballroom
	B6: Poison in the Well: Addressing the Arsenic Crisis in Bangladesh - Cabinet Room
	B7: The Unhealthy Hearth: Indoor Air Pollution from Cooking and Heating Fuels - Congressional Rooms A/B
3:30 - 4 pm	Coffee Break in Exhibition Hall
4 - 5:30 pm	Plenary Session - Health and the Elements: Anticipating Hazards in Our Water and Air - Regency Ballroom
5:30 - 7 pm	Poster Session and Welcome Reception - Exhibition Hall
6:30 - 8 pm	Global Health Council Annual Membership Meeting & Dinner - Diplomat Ballroom

Please note that changes in the schedule may occur. Watch for our Daily Conference Updates!

Thursday, May 29, 2003

7 - 8 am	Continental Breakfast in Exhibition Hall
7:30 am - 5 pm	Registration Open - West Registration Desk
8:30 - 10 am	Plenary Session - Preservation of the People: Population and Urbanization - Regency Ballroom
10 - 10:30 am	Coffee Break in Exhibition Hall
10:30 am - Noon	Concurrent Sessions - C Series
C	C1: X-Fire: Spotlight on Seeds: Biotechnology and the Developing World - Regency Ballroom
	C2: Tools for Prevention: Communication Strategies to Fight HIV/AIDS - Ambassador Ballroom
	C3: Life in Balance: Partnering to Improve Reproductive Health and the Environment - Executive Room
	C4: Strengthening Provider Skills for Child and Reproductive Health - Palladian Ballroom
	C5: Mainstreaming Prevention of Diarrhea in Child Health - Congressional Rooms A/B
	C6: Environmental Issues in Income Generation and Health - Cabinet room
Noon - 1:30 pm	Lunch Break
12:30 - 1:20 pm	Career Connection Brown Bag Session: Careers in Global Health: How We Got Started - Congressional Rooms A/B
1:30 - 3 pm	Concurrent Sessions - D Series
D	D1: Enhancing HIV/AIDS Drug Access Through Regional Pooled Procurement - Congressional Rooms A/B
	D2: Local Outbreak: Community-Based Strategies to Address Infectious Disease - Executive Room
	D3: Healthy Families, Healthy Forests: Integrated Programs - Cabinet room
	D4: Looking at Laws: Issues in Human Rights, Health and the Environment - Ambassador Ballroom
	D5: Local Solutions: Communities Impacting Child Survival - Palladian Ballroom
	D6: Water, Livelihood and Health - Capitol room
3 - 3:30 pm	Coffee Break in Exhibition Hall
3:30 - 5:30 pm	Roundtable Session - Executive Room, Congressional Rooms A/B, Diplomat Ballroom, Palladian Ballroom, Empire Ballroom
5 - 6:30 pm	Pre-Awards Banquet Reception - Exhibition Hall
6:15 - 8:30 pm	Gala Banquet and Awards Ceremony - Regency Ballroom
8:30 - 10 pm	Post-Awards Banquet Reception and Entertainment - Ambassador Ballroom

Friday, May 30, 2003

7:30 - 8:30 am	Continental Breakfast in Exhibition Hall
7:30 am - 5 pm	Registration Open - West Registration Desk
8:30 - 10 am	Concurrent Sessions - E Series
E	E1: Powering Up: Motivating Communities to Improve Health - Regency Ballroom
	E2: On the Job: HIV/AIDS Strategies for the Work Environment - Congressional Rooms A/B
	E3: Malaria, Dengue, Cholera: Environmental Strategies for Control and Prevention - Palladian Ballroom
	E4: Filling the Gaps: Measures for Better Understanding of Gender-Based Violence - Cabinet room
	E5: The Baby's Environment: Improving Newborn Care - Ambassador Ballroom
	E6: Research to Policy: Models that Work for Improving Health and the Environment - Executive Room
10 - 10:30 am	Coffee Break in Exhibition Hall
10:30 am - Noon	Concurrent Sessions - F Series
F	F1: X-Fire: Managing the Spray: The Role of DDT in Malaria Control - Regency Ballroom
	F2: Our Children, Our Future: Reaching Children Affected by AIDS - Congressional Rooms A/B
	F3: Continuum of Care: Essential Pregnancy-Related Services - Executive Room
	F4: Public-Private Partnerships: Resource Mobilization for Health Care - Ambassador Ballroom
	F5: Defining Population-Environment Linkages and Institutionalizing Response - Palladian Ballroom
	F6: Managing Injection Waste: Experience from the Field - Cabinet room
Noon - 1:30 pm	Lunch Break
1:30 - 3 pm	Late Breaking Session Addition: SARS Update - Regency Ballroom
1:30 - 3 pm	Concurrent Sessions - G Series
G	G1: Improving Maternal and Child Health in Urban Slums and Squatter Settlements - Palladian Ballroom
	G2: Best Practices for Reduction of Maternal Mortality: Experiences from Egypt - Congressional Room A
	G3: Advancing Global Alliances for Health: Communication Tools and Strategies - Ambassador Ballroom
	G4: Enabling Environments: Foundations to Mobilize Against HIV/STIs - Congressional Room B
	G5: Environmental Impact and Challenges among Displaced Populations - Cabinet room
	G6: HIV/AIDS and the Environment: What Are the Linkages? - Executive Room
3 - 3:30 pm	Break
3:30 - 5 pm	Plenary Session - The Leadership Imperative: International Cooperation for a Sustainable Future - Regency Ballroom
5 - 7 pm	White Ribbon Alliance Reception and Dance Party - Ambassador Ballroom

Career Connection

EXHIBITION HALL

The Council's annual Career Connection gives job seekers an opportunity to network and explore job opportunities in the field of global health, while also giving employers the opportunity to conduct onsite interviews for positions they are trying to fill. Participants who have registered for Career Connection have access to the Career Resource Center, special career sessions scheduled over three days, and the chance to speak directly with recruiters about organizations and/or positions that interest them.

CAREER RESOURCE CENTER

The Resource Center is the central point for facilitating communication and scheduling between job seekers and recruiters. There are binders of job descriptions that have been submitted by recruiters and any additional positions that have been announced since the binders' printing. Informational and job interviews will be conducted in the interview booths in the Exhibition Hall. Be sure to check in at the Resource Center in the Exhibition Hall for a complete orientation to the center and the interviewing process.

RESOURCE CENTER HOURS:

8 AM – 5 PM, Wednesday, May 28 and Thursday, May 29
8 AM – 11 AM, Friday, May 30

TUESDAY, MAY 27

Career Connection Orientation Session and Social Hour

2 – 5 PM
Empire Ballroom

An overview of the employment outlook in global health, tips for successful job searches, strategies for making the most of the conference, and an opportunity to enjoy refreshments and get acquainted with fellow Career Connection participants.

SPEAKERS:

Laura Dintino, Career Connection Coordinator, Global Health Council

Patrick Shields, President, Global Recruitment Specialists, an independent recruitment firm providing customized comprehensive human resources services worldwide.

PARTICIPANTS WILL:

- Receive their jobs binders.
- Receive an overview of the Career Connection format and the 2003 conference.
- Explore how to conduct an international job search.
- Understand 10 necessary realizations that will lead to a successful job search.
- Learn how to best present themselves as the applicant of choice.

WEDNESDAY, MAY 28

Career Connection Breakfast Session

How to Network at the Conference, Interviewing Skills

7:30 – 8:30 AM
Congressional Rooms A/B

Experienced global health professionals help job seekers understand how to make the all-important "good first impression" as the conference begins and job seekers prepare to go forth for networking and interviewing. Advice on resume writing and interviewing techniques, and invaluable tips on garnering field experience are included.

SPEAKERS:

Cindy Marino, Recruiter, Project HOPE

Tammy Cauler, Recruiter, Project HOPE

Susan Lavezzoli, Deputy Director, Population Leadership Program

THURSDAY, MAY 29

Career Connection Brown Bag Session

Careers in Global Health: How We Got Started

12:30 – 1:20 PM
Congressional Rooms A/B

Grab your lunch and come learn more about organizations working in the international health sphere. Professionals will describe the unique characteristics of their field and how they got started.

SPEAKERS:

Sophia Mukasa Monico, Senior AIDS Program Officer, Global Health Council; native of Uganda; former CEO of The AIDS Support Organization (TASO)

Elaine Murphy, Professor of Global Health, George Washington University, former Director of PATH's Women's Reproductive Health Initiative.

Curtiss Swezy, Consultant, with 30 years of experience in administration, training and evaluation. This included 10 years of government service with USAID, followed by employment with a variety of not-for-profit NGOs.

Recruiters at Career Connection

THE FOLLOWING ORGANIZATIONS ARE SCHEDULED TO PARTICIPATE AS RECRUITERS FOR CAREER CONNECTION

(Confirmed list as of May 1, 2003)

* = on site interviewing

***AFRICARE**
440 R Street, NW
Washington, DC 20001
(202) 462-3614
Contact: William O. Fleming

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)
1600 Clifton Road, NE (MS-E05)
Atlanta, GA 30333
(404) 639-8167
Contact: Virginia Nga Swezy

***CHEMONICS INTERNATIONAL**
1133 20th Street, NW
Washington, DC 20036
(202) 955-4093
Contact: Alison Mitchell

DEVELOPMENT ALTERNATIVES INC.
7250 Woodmont Avenue
Bethesda, MD 20814
(301) 718-8260
Contact: Edie Tewelde

FAMILY HEALTH INTERNATIONAL
P.O. Box 13950
Research Triangle Park, NC 27709
(919) 544-7040
Contact: Maggie Li

ICDDR,B
International Centre for Health and Population Research
GPO Box 128
Dhaka, Bangladesh 1000
8811751 –60
Contact: Ann Gauvin Walton

***INTERNATIONAL MEDICAL CORPS**
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Los Angeles, CA 90064
(310) 826-7800
Contacts: Jean Lamborn and Roslyn Grace

JHPIEGO
1615 Thames Street
Baltimore, MD 21231-3492
(410) 614-0451
Contact: Rebecca Stoltzfus Dineen

***JOHN SNOW, INC.**
1616 N. Fort Myer Drive
11th Floor
Arlington, VA 22209
(703) 528-7474
Contact: Abul Hashem

***JOHNS HOPKINS UNIVERSITY/ HEALTH AND CHILD SURVIVAL FELLOWS PROGRAM**
103 E. Mount Royal Avenue
Suite 2 B
Baltimore, MD 21202
(410) 659-4108
Contact: John M. Seeley

***MANAGEMENT SCIENCES FOR HEALTH**
891 Centre Street
Boston, MA 02130
(617) 524-7766
Contacts: Marcia Herrera and Jennifer Davis

***PATHFINDER INTERNATIONAL**
9 Galen Street
Watertown, MA 02472-4501
(617) 924-7200
Contacts: Marcy Winzer and Edit Schneider

POPULATION LEADERSHIP PROGRAM
Public Health Institute
2168 Shattuck Avenue., Suite 300
Berkeley, CA 94704-1103
(510) 845-8153
Contact: Joyce Prescott

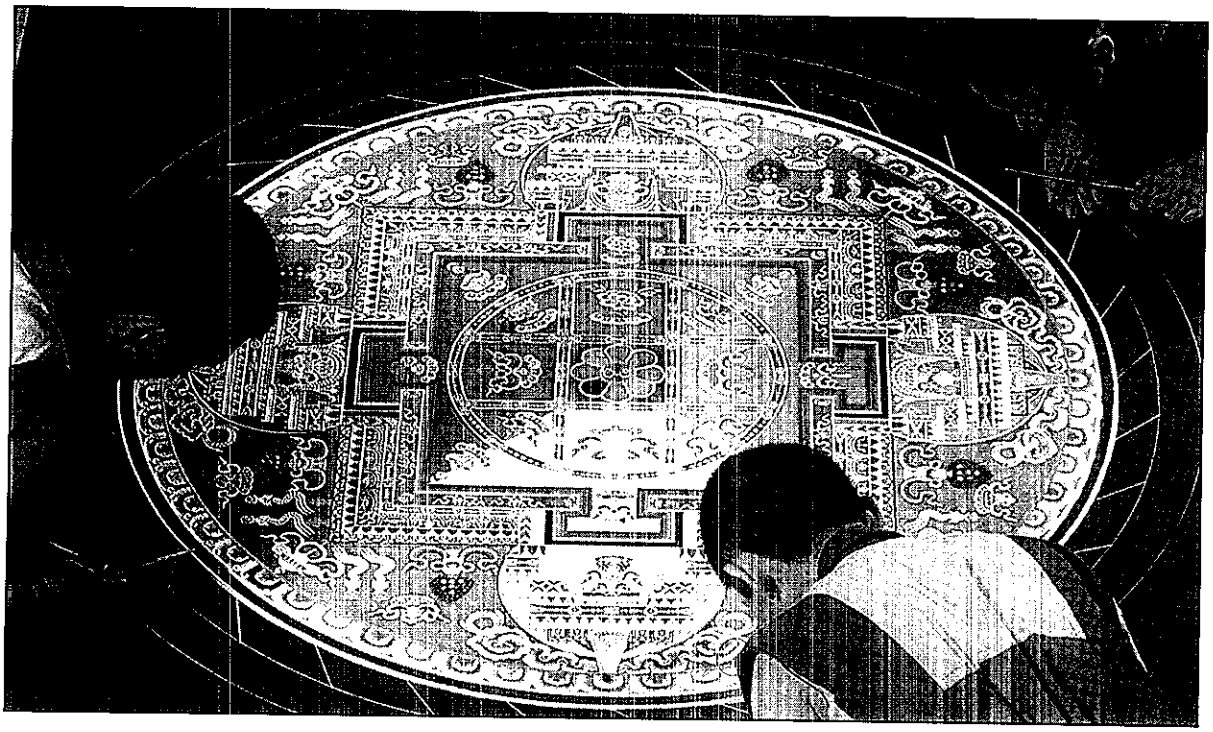
POPULATION SERVICES INTERNATIONAL
1120 19th Street, NW, Suite 600
Washington, DC 20036
(202) 785-0072
Contact: David Olson

PROJECT CONCERN INTERNATIONAL
3550 Afton Road
San Diego, CA 92123
(858) 279-9690
Contact: Janine Schooley

***PROJECT HOPE**
255 Carter Hall Lane
Millwood, VA 22646
(540) 837-2100
Contacts: Cindy Marino and Tammy Cauler

***UNIVERSITY RESEARCH CENTER**
Center for Human Services
7200 Wisconsin Avenue
Suite 600
Bethesda, MD 20814-4811
(301) 941-8407
Contact: Magurette Norris and Tisna Veldhuyzen Van Zanten

Conference Extras



ANNUAL CONFERENCE SPECIAL FEATURE: TAPDIK PEACE MANDALA CONSTRUCTION

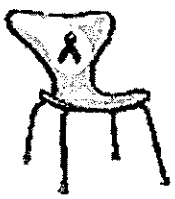
A monk of the Namgyal Monastery in Ithaca, New York will construct a Tapdik Peace Mandala during our Annual Conference. A Mandala or sand painting is a sacred composition representing a pure, perfected universe. They provide a visual and meditative framework for feelings of peace, well-being, wholeness and enlightenment. After three days of detailed work, the Mandala will be dismantled and the sand cast in a body of water. This process symbolizes the transience of life and the ideal of non-attachment to the material world.

BETTY LADUKE

Betty LaDuke is a highly regarded painter and printmaker. She has traveled the earth and shares her experiences with us in her work. Her exhibit "Honor the Earth: Multicultural Journeys" will be on display. The exhibit focuses on Africa, Asia and Latin America and the intimate connection of the people to the earth. Her paintings honor the hands that guide the oxen and plow, hold seed for weeding, sickles for harvesting, baskets for marketing, and food for cooking. Be sure to come by and see her Giclee prints.

HOT SEATS

The Hot Seats Project, a program of the Global Health Council, is designed to educate and mobilize students from colleges and universities to be actively engaged in supporting and promoting an awareness of local and global HIV/AIDS issues through grassroots outreach, coalition building and artistic expression. Look for these decorated chairs at the conference, and read the statements that go along with them.



The chairs represent the seats left empty by those lost to HIV/AIDS, and the statements relay the "hot" issues regarding HIV/AIDS that need to be addressed.

DES STORIES: FACES AND VOICES OF PEOPLE EXPOSED TO DIETHYLSTILBESTROL

DES Stories is a 32-panel exhibit made up of photographic portraits, with first-person narratives telling the impact of DES. A DES Timeline from 1938-2003 shows extensive history, impact, research and consequences. DES Stories educates and brings home the impact of environmental exposure, epidemiological assessment and the big picture of endocrine disruption. Make a point to visit this exhibit.

Panel Sessions by Interest Area – Something for Everyone!

On the following pages, you will find descriptions for each of the sessions offered in this year's program of panel sessions. To facilitate your conference participation, we have grouped the panel sessions into interest areas for your reference and convenience. Please refer to the Conference at a Glance on pages 6–7 or the individual panel descriptions for the times and locations.

Physical Environment and Health: Industrialization and Development

A5: Toxic Exposure: Combating Risk in Urban and Agricultural Settings
A6: The Special Vulnerabilities of Children to Environmental Conditions
C1: X-Fire: Spotlight on Seeds: Biotechnology and the Developing World
C6: Environmental Issues in Income Generation and Health
D3: Healthy Families, Healthy Forests: Integrated Programs
E6: Research to Policy: Models that Work for Improving Health and the Environment
F5: Defining Population-Environment Linkages and Institutionalizing Response
F6: Managing Injection Waste: Experience from the Field
G5: Environmental Impact and Challenges among Displaced Populations
G6: HIV/AIDS and the Environment: What Are the Linkages?

Infectious Disease

A3: It's Back: The Return of Vector Control as a Tool Against Malaria
D2: Local Outbreak: Community-Based Strategies to Address Infectious Disease
E3: Malaria, Dengue, Cholera: Environmental Strategies for Control and Prevention
F1: X-Fire: Managing the Spray: The Role of DDT in Malaria Control

Reproductive and Maternal Health

A4: Gender Inequity and Violence: Challenges in the Social Environment
B4: The Persistence of Inequity: Current Trends in Reproductive Health
B5: Community Participation for Youth Reproductive and Sexual Health
C3: Life in Balance: Partnering to Improve Reproductive Health and the Environment
C4: Strengthening Provider Skills for Child and Reproductive Health
E4: Filling the Gaps: Measures for Better Understanding of Gender-Based Violence
E5: The Baby's Environment: Improving Newborn Care
F3: Continuum of Care: Essential Pregnancy-Related Services
F5: Defining Population-Environment Linkages and Institutionalizing Response
G1: Improving Maternal and Child Health in Urban Slums and Squatter Settlements
G2: Best Practices for Reduction of Maternal Mortality: Experiences from Egypt
G5: Environmental Impact and Challenges among Displaced Populations

Health Systems Policy and Research

A1: People Power: Strategies for Improvement among Health-Care Workers
A7: Health Sector Reform and Financing: Resources and Expenditures
B1: Supply and Demand: Addressing Challenges in Health Service Delivery
B3: Taking Child Health Services to Scale
D1: Enhancing HIV/AIDS Drug Access Through Regional Pooled Procurement
D4: Looking at Laws: Issues in Human Rights, Health and the Environment
E1: Powering Up: Motivating Communities to Improve Health
E6: Research to Policy: Models that Work for Improving Health and the Environment
F4: Public-Private Partnerships: Resource Mobilization for Health Care
G3: Advancing Global Alliances for Health: Communication Tools and Strategies
G4: Enabling Environments: Foundations to Mobilize Against HIV/STIs
G5: Environmental Impact and Challenges among Displaced Populations

Physical Environment and Health: Underdevelopment

A3: It's Back: The Return of Vector Control as a Tool Against Malaria
A6: The Special Vulnerabilities of Children to Environmental Conditions
B2: In the Face of Famine: Increasing Food Security in Sub-Saharan Africa
B6: Poison in the Well: Addressing the Arsenic Crisis in Bangladesh
B7: The Unhealthy Hearth: Indoor Air Pollution from Cooking and Heating Fuels
C3: Life in Balance: Partnering to Improve Reproductive Health and the Environment
C5: Mainstreaming Prevention of Diarrhea in Child Health
D6: Water, Livelihood and Health
E3: Malaria, Dengue, Cholera: Environmental Strategies for Control and Prevention
F1: X-Fire: Managing the Spray: The Role of DDT in Malaria Control
G1: Improving Maternal and Child Health in Urban Slums and Squatter Settlements
G6: HIV/AIDS and the Environment: What Are the Linkages?

HIV/AIDS

A2: Knowing to Caring: VCT, MTCT and Home-Based Care
B2: In the Face of Famine: Increasing Food Security in Sub-Saharan Africa
C2: Tools for Prevention: Communication Strategies to Fight HIV/AIDS
D1: Enhancing HIV/AIDS Drug Access Through Regional Pooled Procurement
E2: On the Job: HIV/AIDS Strategies for the Work Environment
F2: Our Children, Our Future: Reaching Children Affected by AIDS
G4: Enabling Environments: Foundations to Mobilize Against HIV/STIs
G6: HIV/AIDS and the Environment: What Are the Linkages?

Social Environment and Health: Economics and Governance

A7: Health Sector Reform and Financing: Resources and Expenditures
C6: Environmental Issues in Income Generation and Health
D1: Enhancing HIV/AIDS Drug Access Through Regional Pooled Procurement
D3: Healthy Families, Healthy Forests: Integrated Programs
D4: Looking at Laws: Issues in Human Rights, Health and the Environment
E2: On the Job: HIV/AIDS Strategies for the Work Environment
F4: Public-Private Partnerships: Resource Mobilization for Health Care
G4: Enabling Environments: Foundations to Mobilize Against HIV/STIs

Child/Adolescent Health

A6: The Special Vulnerabilities of Children to Environmental Conditions
B3: Taking Child Health Services to Scale
B5: Community Participation for Youth Reproductive and Sexual Health
C3: Life in Balance: Partnering to Improve Reproductive Health and the Environment
C4: Strengthening Provider Skills for Child and Reproductive Health
C5: Mainstreaming Prevention of Diarrhea in Child Health
D5: Local Solutions: Communities Impacting Child Survival
E5: The Baby's Environment: Improving Newborn Care
F2: Our Children, Our Future: Reaching Children Affected by AIDS
G1: Improving Maternal and Child Health in Urban Slums and Squatter Settlements

Conference Co-chairs

His Excellency, Marc Ravalomanana
President of Madagascar

Marc Ravalomanana officially took office as the President of the Malagasy Republic on May 6, 2002. Marc Ravalomanana was born on Dec. 12, 1949, in a family of eight children. He is from Imerikasinina, a village to the east of Antananarivo, where he grew and did his first studies. He is married to Lalao Rakotonirainy and has one daughter and three sons. Marc Ravalomanana is an inspiring example of a self-made man. Starting with a small yogurt processing unit run by his family, and with continual investments, he succeeded in setting up first the TIKO Company, then the TIKO Group, which he chaired until recently. The TIKO Group has become the most successful agro-business in the country and has made Marc Ravalomanana one of the richest men in Madagascar. Marc Ravalomanana went into politics in 1999 as a candidate for Mayor of Antananarivo, the capital city. He won by a large margin and proceeded to make many positive changes. In particular, his improvements in hygiene and sanitation made him immensely popular with the city's residents.

Margaret Catley-Carlson

Honorary Co-chair

Margaret Catley-Carlson is actively involved in organizations that apply science and knowledge to national and international problems in freshwater governance, health, agriculture, environmental protection, international development and development finance. She is chair of The Global Water Partnership, The Center for Agriculture and Bioscience in Wallingford, UK, and The Water Resources Advisory Committee for Suez/Lyonnaise of Paris. She is vice chair of the International Development Research Centre in Ottawa and is on the board of ICARDA (Agricultural Research in Dry Areas) in Syria, and the Library of Alexandria (Egypt). Mrs. Catley-Carlson was president of CIDA, the Canadian International Development Agency (1983-89), and of the Population Council (1991-99). She began her professional career as a career diplomat in Canada; she has been deputy minister of health in Canada, and deputy director (operations) of UNICEF, with the rank of assistant secretary-general of the United Nations. She has received eight honorary degrees and, in 2002, was awarded the Order of Canada.

Thais Corral

Thais Corral is the executive director and founder of REDEH, the Network for Human Development, the first Brazilian organization dedicated to bringing a women's perspective to environmental issues in that country and is a co-founder and current vice president of WEDO (Women's Environment and Development Organization). She is also the founder of CEMINA (Communication, Education and Information on Gender), which has resulted in the establishment of women's programming at more than 400 community and commercial radio stations in Brazil. She is a journalist by training, with a master's in public policy from the Kennedy School of Government at Harvard University. At the Rio Earth Summit in 1992, she organized Planeta Femea, or the Women's Tent, a place where women from the world could meet and share strategies to impact UN and government policies. It was a precursor to her further work of mobilizing women's participation at the string of UN conferences throughout the 1990s, focusing on population and health, human rights, development and women's rights at Beijing.

David Nabarro, MD

David Nabarro is the World Health Organization's executive director for Sustainable Development and Healthy Environments. He also serves as senior policy advisor to the director-general. He joined WHO in 1999 as project manager for the Roll Back Malaria Program, then moved to the Office of the Director-General, as executive director in 2000. David Nabarro qualified as a physician in 1973, then worked in the UK National Health Service. In 1976, he worked for two years as district child health officer in Dhankuta District, East Nepal. He then moved to the London School of Hygiene and Tropical Medicine and was seconded back to Save the Children Fund in 1982 as regional manager for the fund's work in South Asia, based in the region. In 1985, he joined the Liverpool School of Medicine as a senior lecturer in International Community Health. He moved to the British Overseas Development Organization as a strategic adviser for health and population in East Africa, based in Nairobi in 1989. He then took up the post of chief health and population adviser at the ODA London Office in 1990, and moved on to become director of human development (as well as chief health adviser) as ODA was transformed into the Department for International Development in 1997.

Plenary Sessions and Featured Speakers

The Global Health Council is grateful to all the speakers and special guests participating in this year's program and Awards Banquet. All of them have generously donated their time to appear at the conference.

Please note that all Plenary Sessions are held in the Regency Ballroom.

WEDNESDAY, MAY 28, 9-10:30 AM

MAKING THE CONNECTIONS: LINKAGES BETWEEN HEALTH AND THE ENVIRONMENT

Speakers

Nils Daulaire, MD, MPH, president and CEO, Global Health Council
See the full bio on page 100.

Thais Corral, executive director, Brazil s Network for Human Development (Conference Co-chair)
See the full bio on page 12.

Paul Epstein, MD, associate director, Harvard Center for Health and the Global Environment
Paul R. Epstein is a medical doctor trained in tropical public health, and has worked in medical, teaching and research capacities in Africa, Asia and Latin America. In 1992, he attended the Rio Earth Summit and in 1993, coordinated an eight-part series on health and climate change for *The Lancet*. Dr. Epstein was a contributing author for the IPCC (1995) *Second Assessment Report* and served as a principal core author for the WHO/WMO/UNEP book *Human Health and Climate Change* (1996). He has conducted research with support from NOAA's Office of Global Programs and NASA to assess the health impacts of climate change and to develop health applications of climate forecasting and remote sensing.

Stephen Lewis, UN Special Envoy for HIV/AIDS in Africa
Stephen Lewis served as the Canadian Ambassador to the United Nations from 1984-88. In this capacity, he chaired the committee that drafted the Five-Year UN Programme on African Economic Recovery, and also chaired the first International Conference on Climate Change, which drafted the first comprehensive policy on global warming. His work with the United Nations has shaped the past two decades of his career. In the autumn of 1999, he returned to Canada after four years in his appointment as the Deputy Executive Director of UNICEF at the organization's global headquarters in New York. Mr. Lewis was first appointed as Special Representative for UNICEF in 1990. In that capacity, he spoke and traveled regularly, acting as a spokesperson for UNICEF's passionate advocacy of the rights and needs of children, especially children of the developing world. In 1993, he became coordinator for the international study — known as the Graça Machel study — on the "Consequences of Armed Conflict on Children." The report was tabled in the United Nations in 1995. In 1997, in addition to his work at UNICEF, Mr. Lewis was appointed by the Organization of African Unity to the Panel of Eminent Personalities to Investigate the Genocide in Rwanda. The report was issued in June of 2000. He holds 16 honorary degrees from Canadian universities and is a noted radio and television commentator and labor relations arbitrator.

Plenary Sessions and Featured Speakers

WEDNESDAY, MAY 28, 4-5:30 PM

HEALTH AND THE ELEMENTS: ANTICIPATING HAZARDS IN OUR WATER AND AIR

Speakers

Margaret Catley-Carlson, chair, Global Water Partnership (Conference Co-chair)
See the full bio on page 12.

Mike Muller, director-general, Department of Water Affairs and Forestry, South Africa
Mike Muller joined South Africa's Department of Water Affairs and Forestry in 1994 to start the community water and sanitation program, which has since provided water to nearly 8 million people. He helped produce the White Papers on Water Services and a National Water Policy as well as related legislation. He was appointed director-general in September 1997. He has worked extensively at the regional and international level and was a member of the South Africa delegation to the 2002 Johannesburg World Summit on Sustainable Development, during which he chaired the organizing committee of the "Water Dome" parallel event. He has recently been appointed to the UN Secretary General's Millennium Challenge Task Team on water. Mike Muller was born in South Africa, schooled in Swaziland and trained as an engineer in Britain where he worked in London local government until he joined the Mozambique government's National Water Agency in 1979. In 1988, he joined the Development Bank of Southern Africa where he managed infrastructure and policy programs. Before the 1994 elections, he helped prepare the Reconstruction and Development Program of the new South African Government. He has had a long involvement in development policy, advocacy and journalism. In addition to many newspaper and journal articles, he is the author of a number of books and reports on health and development.

Margaret Mwangola, executive director, Kenya Water for Health Organization
Margaret Mwangola is the executive director and one of the founders of the Kenya Water for Health Organization (KWAHO), an organization that has made water available to 1.8 million Kenyans, where she has worked for the past 20 years. She sits on several secondary school and non-governmental boards, including the Africa Centre for Technology, the Network for Water Sanitation, and the Industrial Commercial Development Corporation Investment Company. She is the recipient of many awards, including the Head of State Commendation from the Government of Kenya, and the NCIH (now the Global Health Council) Award for Service in International Health at its 20th Annual Conference in 1993.

Nigel Bruce, PhD, MBBS, public health consultant, University of Liverpool
Nigel Bruce has for the last 10 years worked in collaboration with the World Health Organization (WHO), and a range of other partners including researchers, NGOs and donor agencies, to promote action to reduce the public health impact of indoor air pollution in developing countries. His work spans epidemiological research on health effects of indoor air pollution in children and adults, the development and evaluation of interventions in a range of settings in Asia, Africa and Central America, promoting a better understanding of the links between household energy, health and poverty reduction, as well as policy development and advocacy. Bruce gained his MSc in epidemiology at the London School of Hygiene and Tropical Medicine, and his PhD — an investigation of geographic variations in population levels of blood pressure — from London University. He has been director of the MPH programme at Liverpool University since 1992. His other interests include the promotion and evaluation of health development through community participation and partnership working, in particular with the WHO European Healthy Cities Network. He is also working on accident and injury prevention, and on the development of image and information-based resources to promote knowledge about good practice in health promotion.

Plenary Sessions and Featured Speakers

THURSDAY, MAY 29, 8:30-10AM

PRESERVATION OF THE PEOPLE: POPULATION AND URBANIZATION

Presidential Address by:
His Excellency Marc Ravalomanana, President of Madagascar (Honorary Co-chair)
See the full bio on page 12.

Speakers

Mark Montgomery, PhD, economist, Population Council and SUNY-Stony Brook
Mark R. Montgomery is a senior associate at the Population Council and professor of economics, SUNY-Stony Brook. For the past four years, he has co-chaired (with Richard Stren) the Panel on Urban Population Dynamics, Committee on Population, U.S. National Academy of Sciences. The panel's report, titled *Cities Transformed*, is to be published by the National Academy Press in spring 2003. This report provides a comprehensive assessment of population, health and reproductive health issues in the cities of developing countries, with special emphasis on the roles played by urban poverty and new forms of governance. Montgomery's other research interests include longitudinal studies of family planning, health and schooling in Ghana, and the development of new statistical methods for gauging the effects of poverty on reproductive behavior in poor countries. Montgomery received his PhD in economics from the University of Michigan.

Samir Chaudhuri, MD, director, Children in Need Institute, Kolkata, India
Samir Chaudhuri founded in 1974 the Children in Need Institute (CINI), an NGO that targets its services to deprived women and children living in the slums and villages around Kolkata. Samir Chaudhuri qualified as a physician in 1961 from University of Rangoon and subsequently trained at the All India Institute of Medical Sciences, New Delhi, in 1970 as a pediatrician, specializing in child nutrition. He has served as a consultant to bilateral, international and UN agencies, advising on emergency relief, health and nutrition programs for women and children in many countries of Africa and Asia. Samir Chaudhuri and his colleagues at CINI are part of policy-making bodies at the state and central government levels, and at the Ministries of Health and Family Welfare, and Human Resources Development in India. He is a past president of the Voluntary Health Association of India; president of CINI International; and on the boards of Amici di CINI, Italy, Friends of CINI, Scotland, CINI UK, London and other CINI support groups around the world.

Carolyn Stephens, PhD, senior lecturer in Environment and Health Policy, London School of Hygiene and Tropical Medicine
Carolyn Stephens is a senior lecturer in Environmental Health and Policy and co-director of the Centre for Global Change and Health at the London School of Hygiene and Tropical Medicine, where she has worked since 1991. Since 1999, she has also held an appointment with the Universidad Nacional de Tucuman (UNT), in North-West Argentina, as a profesora titular en Salud Politica y Medio Ambiente. She is now also a visiting professor in the Universidad Federal de Parana in Brazil. She has worked since 1981 in Asia, Africa and Latin America — specifically in India, Liberia, Tanzania, Ghana, Brazil and Argentina. Her research focus is on environmental inequalities, environmental justice and health in developing countries, particularly in participatory projects with disadvantaged communities and children internationally. Most recently, she has moved to work on participatory ways of using epidemiology to support people in analyzing their own health and environmental issues. Carolyn Stephens works with environmental justice and human rights lawyers and with farming communities, local urban groups and marginalized people in the North and South. She has published widely and advises international agencies, governments, NGOs and community groups.

Plenary Sessions and Featured Speakers

FRIDAY, MAY 30, 3:30-5 PM

THE LEADERSHIP IMPERATIVE: INTERNATIONAL COOPERATION FOR A SUSTAINABLE FUTURE

OVERVIEW

Speakers

E. Anne Peterson, MD, MPH, assistant administrator, USAID Bureau for Global Health
E. Anne Peterson is assistant administrator for the U.S. Agency for International Development's Bureau for Global Health, which provides technical and program support to field interventions as part of U.S. foreign aid in the areas of HIV/AIDS, infectious disease control, reproductive health, child and maternal health, environmental health and nutrition. She is an advisor on health policy, testifies before Congress, serves on a variety of inter-agency groups and task forces, works closely with NGOs and with international agencies and host governments throughout the developing world. Previously, she served as the Commissioner of Health for the state of Virginia. She has an extensive background in both U.S. and international public health and medical practice. She has served as a consultant to the Centers for Disease Control and Prevention and the World Health Organization in Haiti and Brazil, designing elephantiasis treatment training materials, and evaluations of educational interventions. She spent almost six years in sub-Saharan Africa (Kenya and Zimbabwe) doing community development, public health training and AIDS prevention, as well performing U.S.-based research in chronic disease prevention, outbreak investigations and food safety. Dr. Peterson obtained her MD from the Mayo Medical School in Rochester, MN, and her MPH and Preventative Medicine residency from Emory University in Atlanta. She is board certified in general preventive medicine and public health.

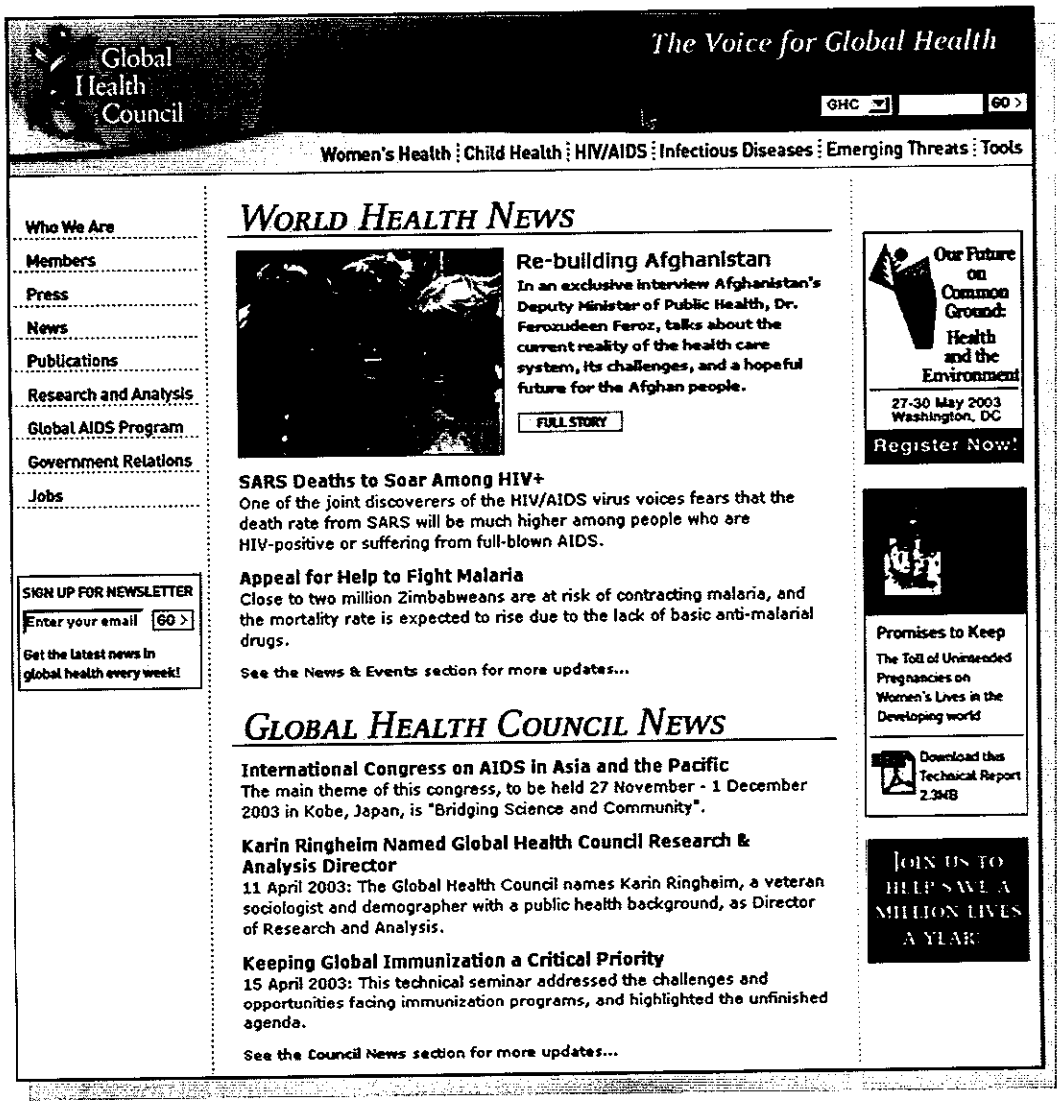
David Nabarro, MD, executive director, WHO s Sustainable Development and Healthy Environments (Conference Co-chair)
See the full bio on page 12.

Jeffrey Sachs, PhD, director, The Earth Institute at Columbia University
Jeffrey D. Sachs is the director of The Earth Institute at Columbia University and a research associate of the National Bureau of Economic Research. He was formerly director of the Center for International Development (CID) and Harvard Institute for International Development (HIID), and the Galen L. Stone Professor of International Trade at Harvard University. Previously, he was chairman of the Commission on Macroeconomics and Health of the World Health Organization, and served as a member of the International Financial Institutions Advisory Commission established by the U.S. Congress. In January 2002, he was appointed by UN Secretary General Kofi Annan as his special advisor on the Millennium Development Goals. Sachs serves as an economic advisor to several governments in Latin America, Eastern Europe, the former Soviet Union, Africa and Asia. He is the recipient of many awards and honors, including the Frank E. Seidman Award in Political Economy, the Distinguished Public Service Award of the Secretary of State's Open Forum, and the Bernhard Harms Prize. He was born in Detroit, MI, in 1954, received his BA, summa cum laude, from Harvard College in 1976, and his MA and PhD from Harvard University in 1978 and 1980, respectively. He joined the Harvard faculty in 1980 and was promoted to full professor in 1983.

Vandana Shiva, director, Research Foundation for Science, Technology and Natural Resource Policy
CANCELLED: Vandana Shiva is unable to attend.

Visit our re-designed website

www.globalhealth.org



Join us online at the Global Health Council's website, where you'll find a wide array of services for health professionals and others concerned about global health issues, including:

- **daily updates** on global health news,
- **notes posted** from the field,
- **job listings** from leading health-related organizations,
- **annotated links** to a wide range of online resources,
- **notices** of available goods and services, conferences, educational programs and other events

Stay in touch with the world of health at www.globalhealth.org

Advocacy Day

Educating Our Leaders and Learning from Each Other

Tuesday, May 27, 2003
9 AM – 4:00 PM

The Global Health Council's Advocacy Day is your chance to impact the decisions of the United States Congress. The Global Health Council invites you to join us in educating members of Congress and their staffs about the need to increase support for global health programs. Advocacy Day is exciting, energizing and one of the most popular events held during the Global Health Council's annual conference.

During Advocacy Day you will:

- Share stories with fellow advocates
- Learn about important global health issues
- Learn effective lobbying and communication skills
- Put your new skills to use during visits to Congressional offices
- Share your personal stories with Congressional members and staffers
- Work and learn with future health leaders and advocates from around the world

Advocacy Day Check-in

8 – 9 AM at the Omni Shoreham Hotel

Advocating for Global Health Training Sessions

9 – 11:30 AM at the Omni Shoreham Hotel

Congressional Luncheon on Capitol Hill

Noon – 2 PM
Transportation to Capitol Hill is provided.

During lunch, participants will hear from U.S. Government representatives who will share their vision and commitment for expanding the Unites States' role in improving global health.

2nd Annual Presentation of the Global Health Action Network Volunteer Award

Influence Leaders!

2:30 – 4 PM

In your assigned Advocacy Team, you will visit a Congressional office to share your stories and try to urge the Congressional Representative to become involved in global health issues.This is an opportunity for you to put the skills you learned in the morning to work. Global Health Council staff will facilitate these visits and will assist you in developing talking points for your meetings.

Program Description

Photo by Catarina Buica

Tuesday, May 27

ADVOCACY DAY EVENTS

8–9 AM

ADVOCACY DAY CHECK-IN

9–11:30 AM
ROOM LOCATIONS ASSIGNED UPON CHECK-IN

ADVOCATING FOR GLOBAL HEALTH TRAINING SESSIONS
Participants will learn how to become powerful advocates for global health. Topics include key global health issues under discussion in the U.S. Congress, as well as pertinent legislation. Participants will learn valuable skills to increase their capacities for being persuasive advocates on these issues. Two concurrent sessions will be offered with tailored trainings for international and domestic participants, so that you can make the most of your time on Capitol Hill.

11:30 AM
OMNI'S PARKVIEW ENTRANCE—EAST CORRIDOR OFF MAIN LOBBY

ONE-WAY TRANSPORTATION TO ADVOCACY DAY EVENTS ON CAPITOL HILL DEPARTS

NOON–2 PM
HART SENATE OFFICE BUILDING, ROOM 902

CONGRESSIONAL LUNCHEON ON CAPITOL HILL
During lunch, participants will hear from congressional representatives and advocates who will share their vision and commitment for expanding the United States' role in improving global health.
Special Event: 2nd Annual Presentation of the Global Health Action Network Volunteer Award

2:30–4 PM

INFLUENCE YOUR LEADERS! CONGRESSIONAL HILL VISITS
In your assigned Advocacy Team, you will visit with congressional staff members to share your stories and to try to urge them to become involved in global health issues. This is an opportunity for you to put the skills you learned in the morning to work. Global Health Council staff will facilitate these visits and will assist you in developing talking points for your meetings.

9 AM–NOON
CAPITOL ROOM

AUXILIARY EVENT: WORKING TOGETHER: THE WORLD BANK'S ROLE IN ACCELERATING PROGRESS TOWARD THE MILLENNIUM DEVELOPMENT GOALS
The first seven Millennium Development Goals (MDGs) are directly or indirectly linked with activities in health, nutrition and population. There are many synergies between health and other sectors, i.e., education, water, sanitation and household energy, influencing health and nutrition outcomes. Working across sectors and strengthening multisectoral approaches will be important to achieving the health-related MDGs. In this session, World Bank staff will share their experiences working cross-sectorally with partners to scale up and accelerate progress toward the MDGs in developing countries.

MODERATOR:
Mariam Claeson, MD, MPH, World Bank

Presenters from the World Bank:
Ian Johnson
Follow-up Action from the World Summit on Sustainable Development

Robert Hecht
Scaling Up Work in Health, Nutrition and Population to Achieve the Health-Related Millennium Development Goals

Tuesday, May 27

Jamal Saghir (invited)
Strengthening the Contribution of the Water Sector to Health Outcomes

Ruth Kagia (invited)
World Bank Efforts to Achieve Education for All: A Critical Determinant of Child Survival

Discussion to follow.

AUXILIARY EVENT: WHITE RIBBON ALLIANCE FOR SAFE MOTHERHOOD
9 AM-2 PM
DIPLOMAT BALLROOM

Please join us to learn how you can be an advocate to promote safe motherhood in the U.S. and around the world. The White Ribbon Alliance (WRA) presents an introductory meeting for all interested in learning more about the WRA, its members, activities and purpose. In the spirit of this year's Global Health Council theme, Health and the Environment, Donna Vivio of the Maternal and Neonatal Health (MNH) Program will present "The Environment, Pregnancy and Women's Health Outcomes: Understanding the Link." She will discuss the role of midwives and other health-care professionals in the protection of the U.S. population, particularly children and pregnant women, from environmental hazards. Following her presentation, a panel of presenters will discuss other environmental issues affecting maternal, newborn and children's health in the U.S. and abroad and various programs to address these concerns. A working lunch will be provided to enable participants to discuss with the presenters and others what they can do in their own communities.

AUXILIARY EVENT: THE REGIONAL FAMILY HEALTH AND AIDS PROJECT: LESSONS LEARNED IN WEST AND CENTRAL AFRICA 1995-2003 HOSTED BY JHPIEGO CORPORATION
9 AM–4 PM
PALLADIAN BALLROOM

Conceived in 1995, the West African Regional Family Health and AIDS Project was the first project of its kind to be implemented on a regional basis. Project staff will discuss the lessons learned from the first phase of this groundbreaking regional project.

SKILL BUILDING WORKSHOPS—MORNING SESSIONS

DELIVERING WINNING PRESENTATIONS
9 AM–NOON
W1
EMPIRE BALLROOM
CMEs: 3.0

Participants will learn how to reduce their anxiety, use effective verbal and nonverbal communication techniques, use questioning techniques, and summarize a presentation. Participants will also learn how to serve as session moderators. This workshop will be of interest to conference speakers, teachers, trainers, students and those who would like to present at conferences in the future.

Workshop Leader:
Richard Sullivan, PhD, JHPIEGO Corporation

A MODERN PARADIGM FOR IMPROVING HEALTH CARE QUALITY
9 AM–NOON
W2
EXECUTIVE ROOM
CMEs: 3.0

Participants will develop knowledge and skills in the principles and methods of modern health-care quality improvement. The workshop is based on the monograph published by the USAID Quality Assurance Project in 2001. The workshop will contain presentation of theoretical material, followed by small group exercises and interactive discussion.

Workshop Leaders:
Rashad Massoud, MD, MPH, Quality Assurance Project, University Research Corporation-Center for Human Services

Thada Bornstein, MEd, Quality Assurance Project, University Research Corporation-Center for Human Services

Tuesday, May 27

SCHEDULE

9 AM–NOON
W3
CONGRESSIONAL ROOM B
CMEs: 3.0

DEVELOPING AN EXPANDED AND COMPREHENSIVE RESPONSE TO THE HIV/AIDS EPIDEMIC

Participants will learn about and apply techniques or methods for expanding the scale and scope of HIV/AIDS programs. The workshop will explore the challenges of implementing a comprehensive response along various pathways of expansion, and will specifically examine 4-5 scenarios to better link and integrate selected technical strategies with their operational requirements.

Workshop Leader:
David Dobrowolski, MEd, MALD, Family Health International
Co-facilitators:
Bill Conn, Rouguiatou Diallo, Janet Kayita, Laura Kayser, Carol Larivee, Melahi Pons and Kenneth Sklaw, Family Health International

9 AM–NOON
W4
CABINET ROOM
CMEs: 3.0

USING BEST PRACTICES TO IMPROVE PROGRAM PERFORMANCE

Participants will learn how to identify interventions that can help program managers meet new objectives, assess appropriateness of interventions in order to scale up successful practices, and use consensus-building to develop action plans for design and implementation. Session is limited to the first 20 pre-registered participants. (If you have not pre-registered, please check with the session coordinator in the Cabinet Room five minutes before the session start to see if space is available.)

Workshop Leaders:
Jeanne Brown, Advance Africa
Lauren Pindzola, MPHc, Advance Africa
Nina Pruyn, MPH, MSW, Advance Africa
Susan Veras, MPHc, Advance Africa

9 AM–NOON
W5
CONGRESSIONAL ROOM A
CMEs: 3.0

USING RESEARCH EVIDENCE TO IMPROVE HEALTH: UNDERSTANDING AND INTERPRETING SYSTEMATIC REVIEWS

Practitioners, policy-makers, managers, consumers and advocates require up-to-date and reliable information on what does and doesn't work in health care. In our search for answers, we are plagued by immense quantities of information varying greatly in quality and/or with divergent or conflicting results. Faced with this situation, health-care decision-makers may fail to notice or simply misinterpret important research. Systematic reviews seek to promote better use of evidence from research through a systematic approach to finding, appraising and summarizing studies. Using case studies relating to health and the environment, this interactive workshop will show how to identify and use key evidence-based health-care resources and discuss factors that need to be considered when applying research evidence in the "real world."

Workshop Leaders:
Colleen Murphy, Global Health Council
Jimmy Volmink, MD, Faculty of Health Sciences, University of Cape Town
Sara Woldehanna, MA, MS, Global Health Council

Tuesday, May 27

Auxiliary Event: Post-Abortion Care Consortium Meeting hosted by JHPIEGO Corporation

12:30 pm–5 pm
Ambassador Ballroom

The Consortium was established in 1993 to encourage international donors in the reproductive health and population field to address the issue of unsafe abortion in its policies and programs. This meeting will update members on the Consortium's ongoing activities. Time will be allocated for individual task force meeting. Those with an interest in PAC who are not Consortium members are encouraged to attend.

SKILL BUILDING WORKSHOPS AFTERNOON SESSIONS

Geographical Information Systems (GIS) in Public Health: Getting Started

1–4 pm
W6
Cabinet Room
CMEs: 3.0

GIS is a relatively new tool in international health projects. This workshop is for those who have heard of GIS but never had a chance to explore it further. The workshop will introduce a basic concept of GIS and give a brief presentation on practical examples of its applications from the fields of environmental health, epidemiology and health service planning. Following brief presentations, the workshop will proceed to hands-on training on GIS software. Participants will be guided through GIS software to produce a simple thematic map. Session is limited to the first 20 pre-registered participants. (If you have not pre-registered, please check with the session coordinator in the Cabinet Room five minutes before the session start to see if space is available.)

Workshop Leaders:
Dairiku Hozumi, MD, MPH, John Snow, Inc.
Eckhard Kleinau, DrPH, MD, Environmental Health Project
Enrique Loyola-Elizondo, MD, Pan American Health Organization

Measuring Morbidity and Mortality Rates in Emergency Surveys

1–4 pm
W7
Congressional Room B
CMEs: 3.0

Participants will learn how to calculate the rates of illness and death from data collected retrospectively in cross-sectional surveys, how to identify potential sources of bias that may influence results, and how to critique the results of surveys that attempt to estimate morbidity or mortality rates. Session is limited to the first 30 pre-registered participants. (If you have not pre-registered, please check with the session coordinator in Congressional Room B five minutes before the session start to see if space is available.)

Workshop Leaders:
Brad Woodruff, MD, MPH, Centers for Disease Control and Prevention
Muireann Brennan, MD, MPH, Centers for Disease Control and Prevention
Linda Bartlett, MD, MHSc, Centers for Disease Control and Prevention

Preparing to Deliver Care and Treatment to People with HIV/AIDS

1–4 pm
W8
Executive Room
CMEs: 3.0

Participants will explore the opportunities and challenges associated with introducing care and treatment interventions in clinic and community settings in resource-poor countries. The workshop will include discussion of infrastructure, human capacity requirements and assessment approaches for delivering care and services, including antiretroviral therapy.

Workshop Leaders:
Mary Lyn Field-Nguer, MSN, FNP, Family Health International
Eric Van Praag, MD, Family Health International
Mukadi Ya Diul, MD, Family Health International

Tuesday, May 27

SCHEDULE

1–4 PM
W9
CONGRESSIONAL ROOM A
CMEs: 3.0

HOW TO STRENGTHEN PRE-SERVICE EDUCATION SYSTEMS
Participants will learn a systematic approach to strengthening pre-service education, and have the opportunity to share their own experiences in working with pre-service systems. The workshop will include an exercise for the direct application of the strengthening process in a realistic situation.

Workshop Leader:
Lois Schaefer, MPH, RN, JHPIEGO Corporation

2–5 PM
EMPIRE BALLROOM

CAREER CONNECTION ORIENTATION SESSION AND SOCIAL HOUR
This session includes an orientation for how to effectively use the Career Connection Resource Center during the conference as well as an overview of the employment outlook in global health, tips for successful job searches, and strategies for making the most of conference. Following the orientation session, a reception gives participants the opportunity to get acquainted with fellow job seekers and recruiters.

Speakers:
Laura Dintino, Career Connection Coordinator, Global Health Council
Patrick Shields, President, Global Recruitment Specialists, an independent recruitment firm providing customized comprehensive Human Resources Services worldwide.

4:30–6:30 PM
CONGRESSIONAL ROOM B

AUXILIARY EVENT: VOLUNTARY COUNSELING AND TESTING IN RESOURCE-POOR SETTINGS: EXPERIENCES WITH SCALING UP, DEMAND CREATION, INTEGRATION, AND RESEARCH PRESENTED BY FAMILY HEALTH INTERNATIONAL
Family Health International will lead a session on the challenges of voluntary counseling and testing (VCT) for HIV/AIDS in resource-poor settings. Using models of successful programs in Kenya, Ethiopia and Rwanda, experts from the field will present subjects ranging from strategies for creating demand for VCT, integrating VCT into family planning and other existing health services, rapid scale up of services, counseling in the context of research studies, and other timely subjects. These brief presentations will be followed by breakout sessions and reportage.

5–6:30 PM
PALLADIAN BALLROOM

AUXILIARY EVENT: ABATING THE SCOURGE OF DISEASE IN AFRICA: A RENEWED CALL FOR INVESTMENT IN HEALTH SYSTEMS HOSTED BY ACOSHED
ACOSHED (The African Council for Sustainable Health Development) advocates for investments in health systems as a vehicle to deliver benefits of interventions that improve health outcomes. The session will present case studies from five African countries as evidence of an urgent need for increased investment in strengthening health systems in Africa.

5–6:30 PM
CABINET ROOM

AUXILIARY EVENT: USAID'S "MAKING CITIES WORK" RECEPTION
The USAID Making Cities Work team (www.makingcitieswork.org) will hold a reception for those who are interested in or currently implement urban health/environmental health projects in the developing world. The team is currently involved in supporting a range of projects designed to increase our understanding of the health challenges faced by the urban poor as well as our ability to improve their health through innovative approaches on the program side. The reception will be an opportunity to meet professionals interested in and working in this field from around the world.

Tuesday, May 27

Auxiliary Event: A Launch of New Resources: Responses to the Needs of Young People hosted by Pathfinder International and the Catalyst Consortium

5–7 pm
Executive Room

Pathfinder International and the Catalyst Consortium are excited to introduce their recent adolescent materials on youth-friendly services, gender and advocacy, as well as present their experiences using these tools in the field.

Auxiliary Event: How to Save a Million Lives a Year: The Health Impact of Handwashing with Soap

5:30–7:30 pm
Diplomat Ballroom

Washing of hands with soap at critical moments is increasingly being acknowledged as a key method of reducing diarrheal mortality and morbidity. The Global Handwashing Initiative seeks to promote scalable handwashing programs through public-private partnerships in select developing countries, with the objective of reducing the incidence of diarrhea. The global partnership consists of client countries, external support agencies (The World Bank, BNWP, WSP, UNICEF, USAID and AED), small and large soap manufacturers, and leading scientific institutions such as the London School of Hygiene and Tropical Medicine (LSHTM) and the Centers for Disease Control (CDC). The session will have presentations from LSHTM and CDC, establishing the impact of handwashing on health.

Mobilizing for More Focused Advocacy

5–8 pm
Congressional Room A

The United Nations HIV/AIDS Declaration of Commitment (UNGASS) is a monumental landmark in the history of the HIV/AIDS epidemic. This session offers a rare opportunity for traditional HIV/AIDS mobilizers and Local Coordinators of the International AIDS Candlelight Memorial to: 1) apprise yourself on what the Declaration of Commitment and the Global Fund to fight AIDS, TB and Malaria are all about: 2) improve your skills sets by benefiting from training on using the Declaration of Commitment and the Global Fund to fight AIDS, TB and Malaria as tools for focused advocacy; as well as 3) closely interact with peers from other regions. This session is organized by the Global Health Council and facilitated by the North American Council of AIDS Service Organization (NACASO) and Canadian Interagency Coalition on AIDS and Development (ICAD).

Auxiliary Event: Reception Hosted by Family Health International

6–8 pm
Empire Ballroom

Auxiliary Event: International Health Section Meeting of the American Public Health Association (APHA)

7 pm Dinner
8 pm Meeting
Off-Site at the Saigon Gourmet Restaurant

The annual mid-year meeting, open to everyone, features dinner, networking, reporting and planning future Section directions, including emerging initiatives in advocacy and public education. Venue: Saigon Gourmet Restaurant, 2635 Connecticut Ave., just a short walk from the Omni Shoreham. Please contact Ray Martin via e-mail at martinrs@aol.com for additional information. Cost for dinner is $20 per person.

Tuesday, May 27

7–9:30 PM
AMBASSADOR BALLROOM

AUXILIARY EVENT: ENVIRONMENTAL HEALTH POLICY CHALLENGES IN A GLOBAL COMMUNITY HOSTED BY THE INSTITUTE OF MEDICINE
The environment, in its broadest sense, is one of the major determinants of human health and well-being. Scientists, health-care workers and policy-makers are beginning to understand the complex interactions between the environment and the genome, and the subsequent impact on the health of individuals and communities. Addressing these environmental health concerns requires cooperation among many agencies, organizations and governments. What is often perceived as a local concern may also have regional, national or international consequences. In response to the need to discuss environmental health from a multi-disciplinarian approach, the Institute of Medicine (IOM) created the Roundtable on Environmental Health Sciences, Research and Medicine as a forum to discuss areas of mutual concern in a neutral environment. This evening session provides an opportunity for individuals to discuss the challenges facing environmental health leaders, the impact of environmental health on global societies, and the need for international cooperation. Following the presentations and discussions, a reception will be held.

Speakers include:
Dr. Lynn Goldman, Professor, Department of Environmental Health, Johns Hopkins University
Dr. Bruce Alberts, President of the National Academy of Sciences (U.S.)
Dr. Harvey Fineberg, President of the Institute of Medicine (U.S.)
Dr. Carlos Santos Burgoa, Director General for Environmental Health of the Federal Health Ministry, Mexico (invited)

7–9 PM
CONGRESSIONAL ROOM B

AUXILIARY EVENT: CHRISTIAN CHILDREN'S FUND WATERSHED PROGRAM IN BRAZIL
The objectives of this program are to protect and restore micro-watersheds and prevent waterborne diseases. In addition, they promote environmental stewardship, use water quality techniques and train communities on hygiene and sanitation.

7:30–9:30 PM
EXECUTIVE ROOM

AUXILIARY EVENT: FORUM ON HEALTH IN THE AMERICAS: HIV/AIDS AND THE HISPANIC COMMUNITY IN THE UNITED STATES HOSTED BY PAHO (PAN-AMERICAN HEALTH ORGANIZATION)
The forum seeks a dialogue between international and local actors dealing with HIV/AIDS issues, with a specific focus on the multisectoral and cultural impacts on prevention and treatment programs.

Wednesday, May 28

7:30–8:30 AM
CONGRESSIONAL ROOMS A/B

CAREER CONNECTION BREAKFAST SESSION: HOW TO NETWORK AT THE CONFERENCE, INTERVIEWING SKILLS
Experienced global health professionals help job seekers understand how to make the all-important "good first impression" as the conference begins and job seekers prepare to go forth for networking and interviewing. Advice on resume writing and interviewing techniques, and invaluable tips on garnering field experience are included.

Speakers:
Cindy Marino, Recruiter, Project HOPE
Tammy Cauler, Recruiter, Project HOPE
Susan Lavezzoli, Deputy Director, Population Leadership Program

Wednesday, May 28

OPENING PLENARY SESSION

MAKING THE CONNECTIONS: LINKAGES BETWEEN HEALTH AND THE ENVIRONMENT

9–10:30 AM
REGENCY BALLROOM
CMEs: 1.5

Human health and the natural environment are part of an inextricably woven system of cause and effect. The degradation and overuse of natural resources have particular effects on children's and women's health. The steady increase in global temperatures has implications for the spread of infectious diseases. AIDS, drought and famine exist in a circular pattern of crisis where lines of cause and effect begin to blur. How can we create fresh strategies that acknowledge and incorporate the connections and interdependencies that influence health and the environment?

Speakers:
Nils Daulaire, MD, MPH, president and CEO, Global Health Council

Thais Corral, executive director, Brazil's Network for Human Development (Conference Co-Chair)

Paul Epstein, MD, associate director, Center for Health and the Global Environment, Harvard Medical School

Stephen Lewis, UN Special Envoy for HIV/AIDS in Africa

CONCURRENT PANEL SESSIONS A SERIES

PEOPLE POWER: STRATEGIES FOR IMPROVEMENT AMONG HEALTH-CARE WORKERS

11 AM–12:30 PM
A1
CONGRESSIONAL ROOMS A/B
CMEs: 1.5

Improving the quality of health services depends largely on the capacities and innovations of health-care delivery workers. Presenters discuss: strategies to improve skills among health workers who lack formal training, efforts of a local team to improve STI screening and treatment, and the application of quality assurance tools to improve provider adherence to treatment guidelines in tuberculosis management.

Moderator:
Mary Taylor, PhD, Consultant

Presenters:
Lahoucine Hassine, MD, Ministry of Health, Morocco
Improving Quality of Sexually Transmitted Infections Services within Peri-urban Communities

Tina Maartens, PhD, University Research Corporation
Strategies to Improve Case Detection, Case Holding and Cure Rates among Tuberculosis Patients in South Africa

Sophia, Mae Tao Clinic, Thailand
Using Evidence to Improve Quality along the Thailand-Burma Border

KNOWING TO CARING: VCT, MTCT AND HOME-BASED CARE

11 AM–12:30 PM
A2
REGENCY BALLROOM
CMEs: 1.5

With the continued growth of the HIV/AIDS pandemic, there is an ever-increasing need for education, counseling, care and support. Presenters discuss: challenges and issues involved in counseling and testing among high-risk populations, breastfeeding education efforts for HIV-positive women, and a monitoring system for the delivery of home-based care.

Wednesday, May 28

SCHEDULE

Moderator:
Gloria Sangiwa, MD, Family Health International

Presenters:
Melissa Barrett, Academy for Educational Development
Preventing Mother-to-Child Transmission of HIV in Zambia

Auguste Kpognon, MBA, Population Services International
Voluntary Counseling and Testing Services for High-Risk Populations in Togo: Military and Youth

Jean-Pierre Sallet, MSc, Management Sciences for Health/EQUITY Project
Monitoring HIV/AIDS Home-Based Care in South Africa

11 AM–12:30 PM
A3
EXECUTIVE ROOM
CMEs: 1.5

IT'S BACK: THE RETURN OF VECTOR CONTROL AS A TOOL AGAINST MALARIA
After many years of decreased attention, malaria control is once again an active topic on the international research and public health agenda. Presenters discuss: current priorities for controlling vector-borne diseases in Africa, the role of vector control vis-à-vis other interventions, and challenges for using the full range of vector control interventions effectively as part of integrated disease control programs.

Moderator:
Matthew Lynch, PhD, MPH, USAID

Presenters:
Juerg Utzinger, PhD, Princeton University
Integrated and Sustainable Malaria Control in Zambia's Copperbelt

Brian Sharp, MD, Medical Research Council of South Africa
Indoor Residual Spraying in Southern Mozambique

Mohammadou Kabir Cham, MD, Roll Back Malaria,
World Health Organization
The Role of Insecticide-Treated Nets in IVM

11 AM–12:30 PM
A4
AMBASSADOR BALLROOM
CMEs: 1.5

GENDER INEQUITY AND VIOLENCE: CHALLENGES IN THE SOCIAL ENVIRONMENT
As the 10th anniversary of the International Conference on Population and Development approaches, difficult issues remain to be addressed. Presenters discuss: the difficulties in collecting data on gender-based violence, the role of inequity in threatening safe motherhood, and the challenges of measuring the impact and outcomes of empowerment strategies.

Moderator:
Jodi Jacobson, Center for Health and Gender Equity

Presenters:
Jill Gay, MA, Futures Group International
The Impact of Gender Inequality on Safe Motherhood

Diana Santillán, MA, Academy for Educational Development
Developing Indicators to Assess Women's Empowerment in Vietnam

Basia Tomczyk, DrPH, MPH, MSc, RN,
Centers for Disease Control and Prevention
A Study on the Prevalence and Magnitude of Gender-Based Violence among Karen-Burmese Refugee Women

Wednesday, May 28

Toxic Exposure: Combating Risk in Urban and Agricultural Settings

11 AM–12:30 PM
A5
Cabinet Room
CMEs: 1.5

Exposure to dangerous chemicals is one of the greatest health risks facing both agricultural workers and urban residents in developing countries. Presenters discuss: education and empowerment efforts to decrease pesticide exposure, and interventions to reduce airborne lead emissions in an industrialized setting.

Moderator:
David Goldsmith, MSPH, PhD, George Washington University School of Public Health and Health Sciences

Presenters:
Tom Luben, MPH, Colorado State University
A Study of the Presence, Use and Distribution of Pesticides in the Río Jigüina Watershed, Matagalpa, Nicaragua

Rita M. Monroy, CES, Farmworker Health Services, Inc.
Pesticide Education in Hispanic Communities of the Americas

Chris Smith, MBA, Chemonics International
Reducing Exposure to Lead: A Critical Urban Health Problem

The Special Vulnerabilities of Children to Environmental Conditions

11 AM–12:30 PM
A6
Palladian Ballroom
CMEs: 1.5

Children are not little adults but people at a unique stage of life: a time at which they are most vulnerable to contaminants and hostile conditions in their environment. Presenters discuss: the state of children's environmental health science and risks associated with water, sanitation and exposure to chemicals.

Moderator:
Robert K. Musil, PhD, MPH, Physicians for Social Responsibility

Presenters:
Katherine M. Shea, MD, MPH, Duke University Medical Center
Improving Children's Environmental Health: From Science to Solutions

Lilian Corra, MD, Asociacion Argentina de Medicos por el Medio Ambiente, Argentina
International Society of Doctors for the Environment–Latin America Children's Special Vulnerabilities to Chemicals

Vanessa Tobin, MSc, United Nations Children's Fund
Why Healthy Children Require Clean Water and Sanitation

Health Sector Reform and Financing: Resources and Expenditures

11 AM–12:30 PM
A7
Governor's Room
CMEs: 1.5

In examining successes and challenges in the implementation of health-care reform, the discussion inevitably returns to the salient issues of governance, infrastructure, political will and capacity. Presenters discuss: an analysis of gaps and inefficiencies in cost recovery efforts at a government dispensary, the effects of a country's decentralization initiative and its impact on equity and provincial funding of population needs, and an examination of the pros and cons in implementing social health insurance in sub-Saharan Africa.

Moderator:
Nancy Pielemeier, Abt Associates

Presenters:
Daniel Maceira, PhD, Center for the Study of the State and Society, Argentina
Decentralization and Equity in a Federal Country, Argentina

Wednesday, May 28

Marty Makinen, PhD, Abt Associates Inc.
Social Health Insurance for Sub-Saharan Africa

Salim B. Sohani, MBBS, MPH, Aga Khan Health Service, Kenya
Cost Recovery Is Futile without Transparent Financial Systems

12:30–2:00 PM
EMPIRE BALLROOM

AUXILIARY EVENT: HIV AND PALLIATIVE CARE PRESENTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION'S HIV/AIDS BUREAU
This special session will address the challenges of integrating the principles and framework of palliative care into the delivery of care and services to people living with HIV/AIDS throughout the continuum of illness. It will focus on the situations faced by vulnerable populations and those living in resource-constrained settings and will present strategies for using the palliative care framework to improve the quality of care and the quality of life of people living with HIV/AIDS.

SCHEDULE

12:45–1:45 PM
PALLADIAN BALLROOM
CMEs: 1.0

USING THE ARTS IN HEALTH INTERVENTIONS
It has been recognized that the use of visual and/or performance art activities can affect behavior change. This exciting presentation format combines the presentation of an abstract describing the use of visual and/or performance art activities in health interventions with a demonstration of those activities.

Presenter:
Edson Whitney, MPS, Johns Hopkins University Center for Communications Programs, Bloomberg School of Public Health
Under the Green Umbrella: Social Dramas for Health

12:45–1:45 PM
EXECUTIVE ROOM

CAMPUS ADVOCACY: MOBILIZING YOUTH FOR GLOBAL HEALTH
Students and young people have been at the cutting edge of social and political change since the founding of our country. However, the rise of organized and networked college students to fight for improved global health is a relatively new phenomenon. The presenters will discuss their work on college campuses, current challenges and successes, and their perceptions of youth involvement in the fight for improved global health. There will also be a "how-to" discussion about how to mobilize students on campus.

Presenters:
Adam Taylor, Executive Director of Global Justice
Amy Klein, founder of the Global Health Chapter at the University of Michigan
Joshua Lozman, Grassroots Coordinator, Global Health Council

CONCURRENT PANEL SESSIONS B SERIES

2–3:30 PM
B1
PALLADIAN BALLROOM
CMEs: 1.5

SUPPLY AND DEMAND: ADDRESSING CHALLENGES IN HEALTH SERVICE DELIVERY
The growing stress on developing country health systems requires that greater attention be paid both to the supply of human resources and to the management of demand for services. Presenters discuss: the growing crisis of the health-care worker shortage, the role of traditional healers in increasing capacity, and the possibilities for shifting services from home to clinic.

Moderator:
Priya Nanda, PhD, Center for Health and Gender Equity

Presenters:
A. Edward Elmendorf, MA, MPH, World Bank
The Silent Crisis of Health Human Resources in Africa

Wednesday, May 28

Mutinta Nyumbu, MD, JSI Research and Training
Trust Between Traditional Healers and Health Workers Makes Better Health

Sidney Ruth Schuler, PhD, MA, Academy for Educational Development
Bangladesh's Health Policies and the Emerging 'Smart Woman'

In the Face of Famine: Increasing Food Security in Sub-Saharan Africa

2–3:30 PM
B2
Governor's Room
CMEs: 1.5

Both man-made and natural environmental conditions in sub-Saharan Africa have contributed to widespread food insecurity situations ranging from chronic malnourishment to acute famine. Presenters discuss: early warning systems and long-term mitigation strategies, as well as the central role of HIV/AIDS in aggravating food insecurity.

Moderator:
Jeanne Downen, MIA, CARE

Presenters:
Charles Chopak, PhD, Chemonics International
Improving Food Security in Africa

Roy Stacey, PhD, Chemonics International
Food Security and HIV/AIDS

Charles H. Teller, PhD, CEDPA
Vulnerability to Food Insecurity and Malnutrition in Ethiopia: A Multilevel Analysis

Taking Child Health Services to Scale

2–3:30 PM
B3
Executive Room
CMEs: 1.5

The implementation of large-scale programs to improve child health requires a careful balance of community mobilization, technical intervention, and sustained commitment and support among key stakeholders. Presenters discuss: policy, programmatic and strategic approaches that are being undertaken to achieve public health impact at scale in Madagascar, India and Nepal.

Moderator:
Tina Sanghvi, The BASICS II Project

Presenters:
Nancy Harris, MPH, John Snow, Inc.
Strategic Concepts and Programmatic Underpinnings of Madagascar's Scaled-Up Family Health Program

T. Usha Kiran, MPH, CARE/India
Working at Scale on Integrated Nutrition and Health Through CARE/India's Program

Ram Shrestha, MSc, MA, National Vitamin A Program of Nepal
Lessons Learned from Scaling Up the Vitamin A Supplementation Program in Nepal

Wednesday, May 28

SCHEDULE

2–3:30 PM
B4
REGENCY BALLROOM
CMEs: 1.5

THE PERSISTENCE OF INEQUITY: CURRENT TRENDS IN REPRODUCTIVE HEALTH
Efforts to improve reproductive health services for the poorest in the world have lagged in spite of significant public health gains. Presenters discuss: cultural conditions that impede progress, a study that suggests the need for programmatic changes in addressing the needs of the poor, and a system of performance-based grants for expanding reproductive health services.

Moderator:
Karin Ringheim, PhD, MPH, Global Health Council

Presenters:
Duff Gillespie, PhD, The Packard Foundation
Persistent Inequalities in Reproductive Health Services

Laurence Laumonier-Ickx, MD, Management Sciences for Health
Rapid Health Services Expansion Through Performance-Based Grants

Alpana Sagar, MBBS, MCH, PhD, Jawaharlal Nehru University
The Impact of the Social Environment on Legitimization of Women's Morbidity

2–3:30 PM
B5
AMBASSADOR BALLROOM
CMEs: 1.5

COMMUNITY PARTICIPATION FOR YOUTH REPRODUCTIVE AND SEXUAL HEALTH
This panel will describe three evaluated community mobilization projects that focus on improving adolescent reproductive and sexual health outcomes. Presenters discuss: project methodology, specific intervention activities and evaluation results.

Moderator:
James Wagoner, Advocates for Youth

Presenters:
Nicole Cheetham, MHS, Advocates for Youth
Communities Take Action for Youth in Burkina Faso

Sanyukta Mathur, MHS, International Center for Research on Women
Community Support for Youth Reproductive Health in Nepal

Amy Weissman, MPH, MS, Save the Children
Mobilizing Communities: Youth to Youth for Healthy Life

2–3:30 PM
B6
CABINET ROOM
CMEs: 1.5

POISON IN THE WELL: ADDRESSING THE ARSENIC CRISIS IN BANGLADESH
Contamination of the Bangladesh underground water supply by naturally occurring arsenic has resulted in the exposure of millions of inhabitants to the risk of poisoning. Presenters discuss: the magnitude of the problem, clinical implications and strategies to prevent and mitigate arsenicosis.

Moderator:
Joseph Graziano, PhD, Columbia University Mailman School of Public Health

Presenters:
Habibul Ahsan, MD, MMedSc, Columbia University Mailman School of Public Health
Combating the Health Effects of Arsenic Exposure from Drinking Water in Bangladesh: Experience from the Columbia University Arsenic Project

Golam H. Rabbani, MD, PhD, FACG,
ICDDR,B Center for Health and Population Research
Drugs and Clean Water Mitigate Arsenic Poisoning in Bangladesh

Abdullahel Hadi, DRPH, BRAC
Controlling the Risk Factors of Arsenicosis in a Poor Community: Experience of BRAC in Bangladesh

Wednesday, May 28

2–3:30 PM
B7
CONGRESSIONAL ROOMS A/B
CMEs: 1.5

THE UNHEALTHY HEARTH: INDOOR AIR POLLUTION FROM COOKING AND HEATING FUELS
Cooking and heating with solid fuels is often the largest indoor source of air pollution in developing countries and can lead to acute respiratory diseases and death, particularly among women and children. Presenters discuss: methods for assessing exposure risk, and strategies to decrease pollution through monitoring efforts and behavior change.

Moderator:
Kseniva Lvovsky, World Bank

Presenters:
Brendon Barnes, MSocSc, South African Medical Research Council
Testing Behaviors to Reduce Indoor Air Pollution Impacts

Majid Ezzati, MEng, PhD, Resources for the Future
Health Benefits of Household Energy Transitions in Kenya

Sumi Mehta, MPH, University of California, Berkeley
Predicting Indoor Air Pollution in Rural Indian Households

PLENARY SESSION

4–5:30 PM
REGENCY BALLROOM
CMEs: 1.5

PLENARY SESSION: HEALTH AND THE ELEMENTS: ANTICIPATING HAZARDS IN OUR WATER AND AIR
An anonymous quotation states "millions have lived without love, but none have lived without water." The same can be said of air, and yet these two essential elements of life often prove to be instruments of disease where clean supplies are insufficient. Each year, 6 million people die and tens of millions more suffer serious illness from a combination of water-related diseases, indoor air pollution, and urban air pollution. What is the state of current research; what efforts are under way to effect change; and what are the prospects for the future?

Moderator:
Margaret Catley-Carlson, chair, Global Water Partnership (Conference Co-chair)

Speakers:
Mike Muller, director-general, Dept. of Water Affairs and Forestry, South Africa
Margaret Mwangola, executive director, Kenya Water for Health Organization
Nigel Bruce, PhD, MBBS, public health consultant, University of Liverpool

POSTER SESSION AND WELCOME RECEPTION

5:30–7 PM
EXHIBITION HALL

Join us in the Exhibition Hall for great food, lots of networking and substantive learning! Meet colleagues, make new contacts, and explore our exhibitors' array of programs and services in an informal and festive atmosphere. Poster presenters will be available throughout the reception to share the results of their work in a creative and interesting visual format.

Please see P2-P3 for a list of the Poster Presentations.

Wednesday, May 28

6–8 PM
CONGRESSIONAL ROOM B

AUXILIARY EVENT: INDOOR AIR POLLUTION: AN INTERVENTION-BASED PERSPECTIVE HOSTED BY THE WORLD HEALTH ORGANIZATION (WHO)
Colleagues working in Guatemala, South Africa, India and China share experiences and emerging evidence related to interventions, their efficacy and cost-effectiveness. This session will include a slideshow of project sites!

6:30–9 PM
PALLADIAN BALLROOM

AUXILIARY EVENT: AFRICAN COMPREHENSIVE HIV/AIDS PARTNERSHIPS (ACHAP)
ACHAP is a joint initiative between the government of Botswana, the Merck Company Foundation and the Bill & Melinda Gates Foundation to advance prevention, care and treatment of HIV/AIDS in Botswana. The presentation will report on the partnership's progress to date.

Presenter:
Linda Distlerath, Vice President, Global Health Policy

GLOBAL HEALTH COUNCIL ANNUAL MEMBERSHIP MEETING & DINNER

6:30–8 PM
DIPLOMAT BALLROOM

The Council's board of directors and staff look forward to hosting our members in this annual event. This year's meeting will feature short presentations by selected member organizations. Dinner to follow.

6:30–8 PM
EXECUTIVE ROOM

AUXILIARY EVENT: HEALTH AND CHILD SURVIVAL FELLOWS PROGRAM
The H&CSFP prepares junior and mid-career health professionals for international careers through two-year, practice-oriented assignments with the U.S. Agency for International Development (USAID) or other similar agencies. USAID assignments can be in overseas field missions or in the U.S. All other assignments are overseas. Eligibility requirements include a master's degree in a health-related field, U.S. citizenship and a commitment to a career in international health. Candidates for specific assignments are selected from a pool of applicants. For further information, or to obtain an application for the candidate pool, visit our booth in the Exhibition Hall or the program's website http://jhuhcsfp.org or contact: Paul R. Seaton, Director (pseaton@jhsph.edu).

Thursday, May 29

PLENARY SESSION

PRESERVATION OF THE PEOPLE: POPULATION AND URBANIZATION

8:30–10 AM
REGENCY BALLROOM
CMEs: 1.5

It is estimated that by the year 2030, 60 percent of all people on earth will live in cities. As urbanization grows, the needs of cities and the people living in them grow as well; and current conditions indicate that much more must be done to meet them. Access to health services in particular is a growing problem among the urban poor, who often exist on the margins of developing world cities in sprawling, unsafe settlements. How can infrastructures be strengthened for improved health and quality of life; and how can the inherent vitality, diversity and creativity of urban settings be best developed to create sustainable cities for its inhabitants?

Presidential Address by
His Excellency Marc Ravalomanana, President of Madagascar
(Honorary Co-chair)

Moderator:
Carolyn Stephens, PhD, co-director, Centre for Global Change and Health
London School of Hygiene and Tropical Medicine

Speakers:
Mark Montgomery, PhD, economist, Population Council
Samir Chaudhuri, MD, director, Children in Need Institute, Kolkata, India

CONCURRENT PANEL SESSIONS C SERIES

X-FIRE: SPOTLIGHT ON SEEDS: BIOTECHNOLOGY AND THE DEVELOPING WORLD

10:30 AM–NOON
C1
REGENCY BALLROOM
CMEs: 1.5

Advances in the field of biotechnology over the past several years have resulted in the development of pesticide-resistant, vitamin-enriched, and other varieties of genetically modified seeds. In this session, presenters explore the many divergent issues that have emerged regarding the application of this technology in the developing world.

Moderator:
Daniel Charles, National Public Radio

Speakers:
Anatole Krattiger, PhD, Strategic World Initiative for Technology Transfer, Cornell University
Jean Halloran, Consumer Policy Institute, Consumers Union
C.S. Prakash, PhD, Center for Plant Biotechnology Research, Tuskegee University
Hope Shand, ETC Group

TOOLS FOR PREVENTION: COMMUNICATION STRATEGIES TO FIGHT HIV/AIDS

10:30 AM–NOON
C2
AMBASSADOR BALLROOM
CMEs: 1.5

As HIV infection rates continue to climb, community advocates and health professionals are constantly challenged to develop strategies for behavior change. Presenters discuss: the untapped potential of youth leaders, the effectiveness of the performing arts, and the incorporation of psychosocial principles as additional items for the prevention toolkit.

Moderator:
Elaine Murphy, PhD, George Washington University

Thursday, May 29

Presenters:
Emmanuel D.K. Fiagbey, MEd, MPhil, Johns Hopkins University Bloomberg School of Public Health
Goal-Directed HIV/AIDS Prevention Strategies: Journey of Hope

Louise Lindenmeyr, RN, FNP-C, Project Troubador
The Performing Arts in HIV/AIDS Prevention in Africa: How to Help Preserve a Fragile Social Ecosystem Through Storytelling Theater

Pako Selemogo, Advocates for Youth
Youth Leaders: Making a Change in the Epidemic

10:30 AM–NOON
C3
EXECUTIVE ROOM
CMEs: 1.5

LIFE IN BALANCE: PARTNERING TO IMPROVE REPRODUCTIVE HEALTH AND THE ENVIRONMENT
Integrated programs that transcend sectoral boundaries can have an impact on the improvement of both reproductive health and conditions in the physical environment. Presenters discuss: projects that work to decrease deforestation, improve agricultural practices, and preserve coastal resources while also improving reproductive health.

Moderator:
Sadhana Hall, MPH, Global Health Council

Presenters:
Naida G. Pasion, Save the Children
Creating Synergy in Integrated Population Health and Environment Programs

Barthelemy Rakototiana, MD, NGOs SAF/FJKM Moramanga
Healthy Communities and Healthy Environment in Madagascar

Erika C. Vohman, MSc, World Neighbors
Impacts of Integrated Reproductive Health and Agriculture Program in North Potosi, Bolivia

10:30 AM–NOON
C4
PALLADIAN BALLROOM
CMEs: 1.5

STRENGTHENING PROVIDER SKILLS FOR CHILD AND REPRODUCTIVE HEALTH
Effective training strategies can lead to increased provider motivation and performance, as well as improved client satisfaction and quality of services. Presenters discuss: several successful programs that have enhanced child and reproductive health services.

Moderator:
Bulbul Sood, MD, MPH, CEDPA/India

Presenters:
Cynthia Eyakuze-Di Domenico, MA, Family Care International
Integrating Youth-Friendly Approaches into Pre-service Nursing Internships

Shalini Shah, MPH, MBBS, Intrah
Skilled Providers, More Clients: Implementing an Essential Service Package in Bangladesh

Amy Shire, MPH, EngenderHealth
Improving Provider Performance in Child Health Services

Thursday, May 29

Mainstreaming Prevention of Diarrhea in Child Health

10:30 am–Noon
C5
Congressional Rooms A/B
CMEs: 1.5

While substantial progress has been made in reducing mortality from childhood diarrhea, morbidity remains high and may even increase. Presenters discuss: how hygiene improvement effectively prevents childhood diarrhea and needs to become central to child health programs together with ORT and case management.

Moderator:
Robert Black, MD, MPH, Johns Hopkins University Bloomberg School of Public Health

Presenters:
Paulin Kalonji, Sanru Basic Rural Health Project, DR Congo
The Sanru Experience: Integrating Hygiene Improvement into Primary Health Care

Robert Kolesar, MPH, John Hopkins University School of Public Health
Combining Hygiene with Hardware for Maximum Impact in the Dominican Republic

Claudio F. Lanata, MD, MPH, Instituto De Investigacion Nutricional, Peru
Trends in Diarrhea Morbidity: Why Prevention Is Important

Environmental Issues in Income Generation and Health

10:30 am–Noon
C6
Cabinet Room
CMEs: 1.5

Environmental issues that impact health are often affected by economic considerations. Presenters discuss: how a polluting weed paradoxically serves as the raw material for income-enhancing products, how training and community leadership can reduce reliance on harmful agricultural techniques, and how a transition to high-value agricultural crop production can result in positive health outcomes.

Moderator:
Lisa Nichols, MPH, Environmental Health Project

Presenters:
Larry Morgan, PhD, MS, Chemonics International
Increasing Rural Nepalese Incomes and Nutritional Status

Stephen Otieno Okoth, MA, University of Nairobi
Water Hyacinth: Its Constraints and Opportunities on Health

Tina Harinjaka Rakotonandrasana, MD, Voahary Salama Association
Three Model Approaches for Effective Integrated Development in Madagascar

Career Connection Brown Bag Session:
Careers in Global Health: How We Got Started

12:30–1:20 pm
Congressional Rooms A/B

Grab your lunch and come learn more about the organizations working in the international health sphere. Professionals will describe the unique characteristics of their field and how they got started.

Speakers:
Sophia Mukasa Monico, Senior AIDS Program Officer, Global Health Council; native of Uganda; former CEO of The AIDS Support Organization (TASO)

Elaine Murphy, PhD, professor of Global Health, George Washington University, former director of PATH's Women's Reproductive Health Initiative.

Curtiss Swezy, consultant, with 30 years of experience in administration, training and evaluation. This included 10 years of government service with USAID, followed by employment with a variety of not-for-profit NGOs.

Thursday, May 29

SCHEDULE

CONCURRENT PANEL SESSIONS D SERIES

1:30–3 PM
D1
CONGRESSIONAL ROOMS A/B
CMEs: 1.5

ENHANCING HIV/AIDS DRUG ACCESS THROUGH REGIONAL POOLED PROCUREMENT

Most people living with HIV/AIDS in developing countries lack access to the drugs they need to prolong and improve their lives. Presenters discuss: recent experiences with regional pooled procurement, which offers hope that access to life-saving medicines can be improved in resource-poor settings.

Moderator:
Keith Johnson, Management Sciences for Health

Presenters:
Francis Burnett, Organization of Eastern Caribbean States
Reducing the Cost of Pharmaceuticals Through Pooled Procurement

James Fitzgerald, PhD, Pan American Health Organization
Pooled Procurement of Antiretrovirals: Opportunities and Challenges

Helena Walkowiak, MSc, Management Sciences for Health
Pooled Procurement in Africa: A Commodity Management Solution?

1:30–3 PM
D2
EXECUTIVE ROOM
CMEs: 1.5

LOCAL OUTBREAK: COMMUNITY-BASED STRATEGIES TO ADDRESS INFECTIOUS DISEASE

Programs to reduce the incidence of infectious disease can be most successful when designed in partnership with the communities affected. Presenters discuss: the use of a societal perspective to reduce STIs in a mining community, a community-based dengue prevention strategy, and a community collaboration to improve the capacity of local clinics in tuberculosis treatment.

Moderator:
Diana Weil, World Bank

Presenters:
Nobanzi Dana, Management Sciences for Health
Battling Tuberculosis on the Frontlines: Enabling Rural Clinics in South Africa

Samuel Duh, MD, MPH, FRSH, CARE International
Gold, Diamonds and Migrant Labor: A Recipe for HIV/AIDS

Julia Rosenbaum, MPH, Academy for Educational Development
Community-Based Dengue Prevention in the Dominican Republic

Thursday, May 29

Healthy Families, Healthy Forests: Integrated Programs

1:30–3 pm
D3
Cabinet Room
CMEs: 1.5

A focus on the population-health-environment nexus can lead to programs that effectively combine reproductive health, conservation and natural resource management. Presenters discuss: success factors, monitoring activities, sustainability and scaling up.

Moderator:
Duff Gillespie, PhD, The Packard Foundation

Presenters:
Odile Randriamananjara, MD, Voahary Salama Association, Madagascar
Working Together: Family Planning and Natural Resource Management

George Strunden, Jane Goodall Institute
Community-Centered Conservation: The Jane Goodall Institute–Tacare Experience in Tanzania

John N. Williams, MA, Conservation International
Health and Hotspots: Why Family Planning Matters to Conservationists

Looking at Laws: Issues in Human Rights, Health and the Environment

1:30–3 pm
D4
Ambassador Ballroom
CMEs: 1.5

An exploration of the connections between human rights, environment and health issues can yield new insights on policy implications. Presenters discuss: strategies to address human rights abuses by transnational corporations, policy implications of human rights treaties for the protection of health and the environment, and an evaluation of the emergence of environmental and occupational risk assessment in Poland.

Moderator:
Stephen P. Marks, Docteur d'Etat, Dipl. IHEI, François-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health

Presenters:
Kathleen Allden, MD, Dartmouth Medical School
Medical-Legal Documentation of Human Rights Abuses by Transnational Corporations

Curtis Doebbler, PhD, JD, LLM, Distinguished Lecturer in Law and Politics
Health and the Environment as Human Rights

Gabriela Kernan, MPH, WS Atkins Polska
Environmental and Occupational Health in Poland

Local Solutions: Communities Impacting Child Survival

1:30–3 pm
D5
Palladian Ballroom
CMEs: 1.5

Community involvement in both behavior change strategies and coordination of services can have an impact on reducing child morbidity and mortality. Presenters discuss: programs that use volunteer networks to implement behavior change and communication strategies, and community partnerships with public/private sector entities to expand services.

Moderator:
Karen LeBan, The CORE Group

Presenters:
Paul Mkandawire, World Relief Corporation
Effective Community Mobilization for Health Action in Larger Communities

Thursday, May 29

Melanie Morrow, MPH, World Relief Corporation
Child Survival: Empowering Communities to Take Action

Daiyabu Muhammed, Kano State Ministry of Health
Extending Child Health Services into Nigerian Communities

1:30–3 PM
D6
CAPITOL ROOM
CMEs: 1.5

WATER, LIVELIHOOD AND HEALTH
Changes in hygiene behavior can be achieved and sustained through participatory processes that engage the community in managing their own water and sanitation systems. Presenters discuss: successful efforts at the community level using appropriate, local-level technologies.

Moderator:
Brandt Witte, Peace Corps

Presenters:
Ricardo Mancía, Private International Humanitarian Organization
Sustainable Health Benefits from Community-Managed Water Systems in El Salvador

Anita Miya, MA, Aga Khan Foundation
The Village Coverage Approach for Water Supply and Sanitation Systems, State of Gujarat, India

Rebeka Sultana, MD, MPH, Plan Bangladesh
Women-Managed Sanitation Project in Rural Bangladesh

ROUNDTABLE SESSION

3:30–5:30 PM
CMEs: 2.0

This popular, interactive session allows conference participants an opportunity for in-depth learning and networking with presenters in small group discussions. This year, the session will be presented in five simultaneous sessions in separate rooms divided according to the conference themes and key health issues. There will be two one-hour presentation periods during the session, with two presenters at a table. Each presenter will give a 15-minute presentation followed by a 30-minute question-and-answer period, ensuring lively discussion and learning. The two presentation periods will allow participants the opportunity to move to a different table or room between presentation periods, based upon their areas of interest.

(Please see pages R2-R5 for a list of the presentations in each room)

EXECUTIVE ROOM
HIV/AIDS

CONGRESSIONAL ROOMS A/B
Health and Human Rights

DIPLOMAT BALLROOM
Physical Environment and Health: Industrialization and Development
Physical Environment and Health: Underdevelopment

PALLADIAN BALLROOM
Social Environment and Health: Demographics
Health Systems

EMPIRE BALLROOM
Adolescent Reproductive Health
Reproductive and Maternal Health

Thursday, May 29

Auxiliary Event: Alumni Reception, Tulane University School of Public Health and Tropical Medicine
Alumni, current students, friends and prospective students are welcome to attend this reception to meet old friends, make new ones and hear about the latest activities at Tulane's School of Public Health and Tropical Medicine.

5–6:30 PM
Birdcage Walk

GLOBAL HEALTH COUNCIL ANNUAL AWARDS BANQUET

Pre-Awards Banquet Reception
This evening's special festivities begin in the Exhibition Hall with refreshments and hors d'oeuvres as we gather prior to the start of the Awards Banquet.

5–6:30 PM
Exhibition Hall

Annual Awards Banquet
Please see pages 51-58 for a description of the awards and winners.

6:15–8:30 PM
Regency Ballroom

Speakers:
Carole Simpson, ABC News Anchor–Banquet Host
Mamphela Ramphele, MD, Managing Director, World Bank
William Foege, MD, Distinguished Fellow at the Bill & Melinda Gates Foundation, Chair of the Board of Directors of the Global Health Council

Post-Awards Banquet Reception and Entertainment
Join us following the Awards Banquet for celebratory cheer and entertainment.

8:30–10 PM
Ambassador Ballroom

Friday, May 30

Building Successful Partnerships, facilitated by the Global Partnerships staff of the Global Health Council
Join this session and learn about best practices on building successful partnerships. This is a chance to listen to partners from around the world about their experiences and challenges.

8–10 AM
Diplomat Ballroom

CONCURRENT PANEL SESSIONS E SERIES

Powering Up: Motivating Communities to Improve Health
Mobilizing communities to actively participate in the management of their own health involves many issues and challenges. Presenters discuss: psychosocial issues and their effect on community self-perceptions, efforts to reestablish community-based health care in a post-conflict setting, and the potential for local self-help groups to contribute to the control and management of infectious disease.

8:30–10 AM
E1
Regency Ballroom
CMEs: 1.5

Moderator:
Allen Jones, PhD, MA, American Public Health Association

Presenters:
Carolina González Schlenker, MD, MPH,
Sixteenth Street Community Health Center
Social Capital in Poor Communities: Don't Forget Empowerment

Edwina Pereira, RN, MN, International Services Association, India
Health by and of the Communities

Jon E. Rohde, MD, Management Sciences for Health
Building a System of True Community-Based Health Care in Afghanistan

Friday, May 30

SCHEDULE

8:30–10 AM
E2
CONGRESSIONAL ROOMS A/B
CMEs: 1.5

ON THE JOB: HIV/AIDS STRATEGIES FOR THE WORK ENVIRONMENT
HIV/AIDS education and behavior change strategies can also be effective when incorporated into workplace settings. Presenters discuss: efforts to build awareness in the workplace through peer educator programs, and by engaging a for-profit provider of employee health services.

Moderator:
Clarence Hall, DrPH, Africare

Presenters:
Ann Levin, PhD, MPH, Family Health International
Cost-Effectiveness of Peer Educator Programs for Mobile Construction Workers in Vietnam

Meaghan Smith, MIA, Summa Foundation
Changing the Environment for the Private Health Sector

Xiaoming Sun, MD, MSc, Nanjing College for Population Program Management
Implementing a Workplace-Based AIDS Education Program among Floating Unmarried Young Workers in East China

8:30–10 AM
E3
PALLADIAN ROOM
CMEs: 1.5

MALARIA, DENGUE, CHOLERA: ENVIRONMENTAL STRATEGIES FOR CONTROL AND PREVENTION
Effective control of infectious disease is dependent on strategies that address components of both the physical and social environment. Presenters discuss: successful efforts to prevent cholera outbreak in a natural disaster setting, implementation of malaria control strategies using a coordinated public awareness campaign, and the identification of best practices in dengue fever prevention and control.

Moderator:
George Curlin, MD, National Institutes of Health

Presenters:
Franklin Broadhurst, International Rescue Committee
Volcano Eruption in Goma: Avoiding a Cholera Outbreak

Linda S. Lloyd, DrPH, MPH, Environmental Health Project
Best Practices in Dengue Prevention and Control

Josephine Akakulubelwa Nyambe, RN, Zambia Integrated Health Programme
Moving Country Partnerships to Control Malaria

8:30–10 AM
E4
CABINET ROOM
CMEs: 1.5

FILLING THE GAPS: MEASURES FOR BETTER UNDERSTANDING OF GENDER-BASED VIOLENCE
Lessons learned from recent studies on gender-based violence offer insights for program planning and implementation. Presenters discuss: the development and validation of a scale to measure gender-equitable norms, findings from a survey measuring gender-based violence in a conflict/post-conflict setting, and results of a study assessing male behavior and attitudes in gender-based violence.

Moderator:
Samuel Clark, ScD, Program for Appropriate Technology in Health

Presenters:
Gary Barker, PhD, Instituto Promundo
Men, Gender Violence and Sexual and Reproductive Health: A Qualitative and Quantitative Study with Men Ages 15-60 in Rio de Janeiro

Michele Hynes, MPH, Centers for Disease Control and Prevention
Gender-Based Violence Research in East Timor: Lessons Learned

Julie Pulerwitz, ScD, Population Council
Measuring Gender-Equitable Norms: Validation of the Gem Scale

THE BABY'S ENVIRONMENT: IMPROVING NEWBORN CARE

8:30–10 AM
E5
AMBASSADOR BALLROOM
CMEs: 1.5

The health and family care environment established in the first weeks of a newborn's life is critical for prevention of neonatal morbidity and mortality. Presenters discuss: the role of qualitative research in illuminating quantitative results in neonatal care, tools to measure the cost and effectiveness of breastfeeding interventions, and the family perspectives, decision-making and practices that impact the pregnancy, delivery and neonatal periods.

Moderator:
Anne Tinker, MPH, Save the Children

Presenters:
Grace Chee, Abt Associates Inc.
Cost and Effectiveness of Breastfeeding Interventions in Ghana

Marwa Kamel, Egypt Healthy Mother/Healthy Child Project
Cultural/Behavioral Research in a Neonatal Care Campaign: Egypt

Omrana Pasha, MD, MSPH, Save the Children Federation, Inc.
Delivery and Newborn Care in Pakistan: Practices and Communication

RESEARCH TO POLICY: MODELS THAT WORK FOR IMPROVING HEALTH AND THE ENVIRONMENT

8:30–10 AM
E6
EXECUTIVE BALLROOM
CMEs: 1.5

Policy-makers often make decisions based on insufficient scientific evidence, while researchers try in vain to influence policy. Presenters discuss: models for improving the interaction between research and policy in health and the environment.

Moderator:
Rachel Nugent, Fogarty International Center, National Institutes of Health

Presenters:
Lawrence Haddad, PhD, International Food Policy Research Institute
Research, Policy and Governance: Exploring the Connections

Jean Lebel, PhD, International Development Research Centre
Policy Applications of Ecosystem Approaches to Human Health

Natalia Dinello, Global Development Network
Bridging Research and Policy in Health and the Environment

CONCURRENT PANEL SESSIONS F SERIES

X-FIRE: MANAGING THE SPRAY: THE ROLE OF DDT IN MALARIA CONTROL

10:30 AM–NOON
F1
REGENCY BALLROOM
CMEs: 1.5

Although the use of DDT has been banned for several decades in the developed world, it continues to be viewed as a critical weapon in the fight against malaria in developing countries. Presenters in this session share their differing views on the appropriate role of DDT in an overall vector control strategy, the implications and potential impact of the Stockholm Convention on Persistent Organic Pollutants, and prospects for alternative control methods in the future.

Moderator:
Janet Raloff, Science News

Presenters:
Clive Shiff, PhD, Johns Hopkins University School of Public Health
Jacob Williams, MD, Roll Back Malaria Secretariat, World Health Organization
Donald Roberts, PhD, Uniformed Services University
Richard Liroff, PhD, World Wildlife Fund

10:30 AM–NOON
F2
CONGRESSIONAL ROOMS A/B
CMEs: 1.5

OUR CHILDREN, OUR FUTURE: REACHING CHILDREN AFFECTED BY AIDS
As AIDS continues to ravage adult populations, the growing crisis of children orphaned by the disease poses a critical public health and development challenge. Presenters discuss: income-generating projects to address the needs of these children and their caregivers, implementation of a long-term developmental approach to build the capacity of families and communities to provide a basic package of services, and efforts to understand and address the environmental factors that lead to this vulnerable population's increased risk of contracting HIV/AIDS.

Moderator:
Donna Espeut, PhD, MHS, ORC Macro

Presenters:
Milton B. Amayun, MD, MPH, World Vision International
Meeting the Growing Challenge of Africa's AIDS Orphans

Prisca N. Nemapare, PhD, MS, Zienzele Foundation
Community-Based Strategies for Sustainable Projects Improving the Quality of Life of AIDS Orphans

E.K. Vinayakan, MA, Project Concern International
Reducing High-Risk Behavior of Street Children in Delhi

10:30 AM–NOON
F3
EXECUTIVE ROOM
CMEs: 1.5

CONTINUUM OF CARE: ESSENTIAL PREGNANCY-RELATED SERVICES
Improvement of essential services is vital in the effort to improve women's health and reduce maternal mortality. Presenters discuss: a skilled care system to provide essential services to women and newborns from pregnancy through the postpartum/newborn periods, results of a national needs assessment using UN Process Indicators for monitoring obstetric services for the prevention of maternal mortality, and culturally sensitive strategies for extension of post-abortion care services in a highly conservative environment.

Moderator:
Barbara Crane, PhD, Ipas

Presenters:
Pamela Bolton, MHS, Family Care International
Taking Post-abortion Care to Scale Despite Formidable Conservatism

Patricia P. Gomez, MPH, JHPIEGO Corporation, Maternal And Neonatal Health Program
The Skilled Attendant: Essential Competencies and Responsibilities

Mostafa Tyane, MD, MPH, Ministry of Health, Morocco
Availability of Emergency Obstetric Care in Morocco

Friday, May 30

Public-Private Partnerships: Resource Mobilization for Health Care

10:30 AM–Noon
F4
Ambassador Ballroom
CMEs: 1.5

The role of the private sector in mobilizing resources for improved health continues to grow and diversify as new partnerships are created. Presenters discuss: efforts to build sustainable health delivery systems through private sector product delivery in urban areas, the establishment of community health committees to improve local governance of health-related issues, and a market financing strategy leveraging investments in environmental improvements to reduce industrial threats to health.

Moderator:
Isabel Stout, MA, Catalyst Consortium

Presenters:
V.G. Krishnan, MBA, Futures Group International
Creating and Sustaining Partnerships with Commercial Firms

Henry Koner, Chemonics International
Tapping Market Financing to Reduce Threats to Health from Industrial Pollution

David Shear, MA, Citizens International
Public-Private Sector Funding for Health Care in Nigeria

Defining Population–Environment Linkages and Institutionalizing Response

10:30 AM–Noon
F5
Palladian Ballroom
CMEs: 1.5

Defining and responding to linkages between population, health and the environment has been an ongoing focus for academics and practitioners concerned about population dynamics, reproductive health and environmental conservation. Presenters discuss: different approaches to integrating the population, health and environment sectors, and successful methodologies for integrating reproductive health and conservation interventions.

Moderator:
Frank Zinn, The Population Fellows Program, University of Michigan

Presenters:
Roger-Mark De Souza, MA, Population Reference Bureau
Influencing Environmental Health Policy: Experiences from the South

Clare Ginger, PhD, MS, MSL, University Of Vermont
Organizational Action for Responding to Population-Environment Linkages

James D. Nations, PhD, MA, MS, Conservation International
Achieving Integrated Population-Environment Programs in Biodiversity Hotspots

Managing Injection Waste: Experience from the Field

10:30 AM–Noon
F6
Cabinet Room
CMEs: 1.5

Disposal of injection waste poses challenges to staff at all levels of the health system in developing countries. Presenters discuss: common practices and challenges for injection-waste disposal based on recent field research, and approaches to improve safe disposal practices for injection waste, including technological and policy-level solutions.

Moderator:
Paula Nersesian, RN, MPH, John Snow, Inc.

Presenters:
Jules Millogo, MD, MSc, John Snow, Inc./BASICS II
Injection-Waste Management Approaches in Senegal and Guinea

Friday, May 30

Gregory Pappas, MD, PhD, ORC Macro
Infection Control in Health Facilities: Findings from Uganda

Janet Vail, MPH, MBA, Program For Appropriate Technology In Health
Safe Needle Removal to Manage Infectious Sharps

Noon–1:30 pm
Diplomat Ballroom

Covering Global Health: Whose Side is the Media On?
Is the media objective in its coverage or is it a watchdog of institutions and governments working in global health? How do reporters and editors navigate conflicts in news judgment? Whom does the media turn to when seeking expert opinions? Why are some issues ignored? A panel of distinguished national and international journalists representing organizations such as *The Washington Post, The Boston Globe, The New York Times,* network television and international radio will answer these questions and discuss what they cover, why they cover it, and the struggle to get the story right.

12:15-1:15 pm
Executive Room

Auxiliary Event: Book Discussion: Community-Based Health Care: An Idea Whose Time Has Come...or Passed?
Based on the book *Community-Based Health Care: Lessons from Bangladesh to Boston,* edited by Jon Rohde and John Wyon, this session aims to engage participants in an interactive dialogue regarding the successes, limitations, challenges and lessons learned in community-based care.

Discussion Leader:
Jon Rohde, MD, Management Sciences for Health

1:30–3 pm
Regency Ballroom
CMEs: 1.5

Late-Breaking Session Addition: SARS Update
Given the sobering developments with Severe Acute Respiratory Syndrome (SARS) over the past two months, the Council has added this late-breaking session for an update on the current efforts to control and prevent SARS, discussion and awareness-building on the challenges inherent in detecting and containing the spread of this and other emerging diseases, and the need for further investment in this area on a global level.

Moderator:
Nils Daulaire, MD, MPH, Global Health Council

Speakers:
David Heymann, MD, Communicable Diseases Division, World Health Organization

Mary Wilson, MD, Harvard School of Public Health

Julie Gerberding, MD, Centers for Disease Control

Friday, May 30

CONCURRENT PANEL SESSIONS—G SERIES

Improving Maternal and Child Health in Urban Slums and Squatter Settlements

1:30–3 PM
G1
Palladian Ballroom
CMEs: 1.5

The quest for better livelihood opportunities has led to large-scale migration and the mushrooming of slums in many parts of the developing world. Presenters discuss: challenges and progress made in providing health programs for children living in urban slums and squatter settlements, efforts to collect and analyze data disaggregated by urban poor and non-poor, strategies for child health programs in complex urban settings, and case studies of successful slum interventions.

Moderator:
John Borrazzo, PhD, USAID

Presenters:
Siddharth Agarwal, MBBS, USAID-Environmental Health Project
Urban Health Program
Challenges of Urban Programming for Child Health

Fred Arnold, PhD, ORC Macro
Data on the Health of Urban Poor Children

W. Abdullah Brooks, MD, MPH, ICDDR,B Center For Health And Population Research
Making It Work: Epidemiological Profile and Critical Interventions for Dhaka Poor

Best Practices for Reduction of Maternal Mortality: Experiences from Egypt

1:30–3 PM
G2
Congressional Room A
CMEs: 1.5

Maternal death is a tragedy affecting an estimated 600,000 women worldwide every year, but in the past decade Egypt has experienced a dramatic decline in its maternal mortality rate. Presenters discuss: results of a national survey completed in 2000, and causes/interventions that led to the dramatic decline, including: competence-based training, quality assurance, and information, education and communication activities.

Moderator:
Reginald Gipson, John Snow, Inc.

Presenters:
Wafaie El-Sakkary, MD, John Snow, Inc.
Reducing Maternal Mortality and Morbidity in Egyptian Obstetric Departments Through Quality Assurance

Esmat Mansour, PhD, MSc, MBBCH, Ministry of Health And Population, Egypt
The National Maternal Mortality Study: Egypt, 2000

Nahed Matta, MPH, MB, PLAB, USAID
Best Practices for the Reduction of Maternal Mortality in Upper Egypt

Advancing Global Alliances for Health: Communication Tools and Strategies

1:30–3 PM
G3
Ambassador Ballroom
CMEs: 1.5

Communication plays a critical role in supporting the impact of technical activities and promoting the outcomes and successes to donors and other external audiences. Presenters discuss: the importance of effective communications from the donor perspective, and two examples of communication strategies that have been developed to support project activities and promote project successes.

Moderator:
Gretchen Hurley Leitch, Management Sciences for Health

Presenters:
Sandra Jordan, MA, USAID
Building Support: Communicating the Importance of Public Health

Penelope A. Riseborough, John Snow, Inc.
Using Communications to Support Technical Activities in Uganda

Carmen Urdaneta, MPH, Management Sciences for Health/South Africa
Communicating Health Impact: Lessons from South Africa

1:30–3 PM
G4
CONGRESSIONAL ROOM B
CMEs: 1.4

ENABLING ENVIRONMENTS: FOUNDATIONS TO MOBILIZE AGAINST HIV/STIs
Strategies for HIV and STI prevention can have greater impact when efforts are made to establish a supportive social environment. Presenters discuss: how participatory learning and action can be used in adolescent reproductive health programs as a learning process for both youth and adult stakeholders, the role of government and communities in effecting political and legislative change to improve the social environment, and the potential for community mapping exercises to create local empowerment and momentum for change.

Moderator:
Ruth Hope, Synergy Project

Presenters:
Alfredo Fort, PhD, MD, Intrah
A New Sense of Place: Community Mapping in the Dominican Republic's Bateyes

Qian Geng, MEd, Program For Appropriate Technology In Health (PATH)
Improving the Social Environment with Participatory Learning and Action as an Intervention for an Adolescent Reproductive Health Project in China

Nakku Rosette, MPH, Nkumba AIDS Community Initiative
Role of Government, Communities and Political Change in Promoting an Enabling Environment for Effective HIV/AIDS Prevention

1:30–3 PM
G5
CABINET ROOM
CMEs: 1.5

ENVIRONMENTAL IMPACT AND CHALLENGES AMONG DISPLACED POPULATIONS
The special challenges involved in caring for populations displaced by conflict involve a range of social and physical environmental issues. Presenters discuss: the successful integration of refugee services into a local district health system, a study to analyze post-conflict reproductive behavior, and the potential for addressing environmental effects of conflict in an integrated response to complex humanitarian emergencies.

Moderator:
Ron Waldman, MD, MPH, Columbia University Mailman School of Public Health

Presenters:
Rhoda Margesson, PhD, Congressional Research Service
Linking Environmental Concerns and Health in Complex Humanitarian Emergencies

Therese McGinn, MPH, Columbia University Mailman School of Public Health, Heilbrunn Center for Population and Family Health
The Effects of War on Fertility: The Case of Rwanda

Elizabeth Rowley, MIA, MHS, Johns' Hopkins University Bloomberg School of Public Health
The Integration of Refugee and Local Health Systems

Friday, May 30

HIV/AIDS and the Environment: What Are the Linkages?

1:30–3 PM
G6
Executive Room
CMEs: 1.5

HIV/AIDS is having devastating impacts on the environment in Africa, through loss of conservation capacity, changes in land use, unsustainable use of natural resources (wildlife and plants), and loss of indigenous knowledge on medicinal plants and traditional natural resource management. Presenters discuss: direct and indirect impacts resulting from the linkages between HIV/AIDS, rural livelihoods, human capacity and the environment, coping strategies that are being developed by communities, resource users, governments and conservation organizations to deal with the impacts of the disease, and further actions needed.

Moderator:
Judy Oglethorpe, World Wildlife Fund

Presenters:
Daulos Mauambeta, Wildlife and Environmental Society of Malawi
Impacts on Land and Resource Use and Solutions

Barbara Meier, KwaZulu Natal Wildlife Department
Institutional Impacts and What Can Be Done

Marc Barany, MSc, Virginia Polytechnic Institute and State University
Treating AIDS Side Effects with Traditional Remedies and the Impacts on Medicinal Plants

CLOSING PLENARY SESSION

The Leadership Imperative: International Cooperation for a Sustainable Future

3:30–5 PM
Regency Ballroom
CMEs: 1.5

One effect of a continuously globalizing world is to make ever-closer neighbors of us all, highlighting the need for greater international cooperation to address a growing list of issues and concerns that transcend national boundaries. The past decade has witnessed a series of international conferences, treaties and initiatives aimed at addressing health, development, economic and environmental conditions around the world. What effect have these activities had in stimulating action and leadership at the national and multi-national level? How do our international leaders measure up in their response to some of the most critical issues of our age?

Moderator:
E. Anne Peterson, MD, assistant administrator, USAID Bureau for Global Health

Speakers:
David Nabarro, MD, executive director, WHO's Sustainable Development and Healthy Environments

Jeffrey Sachs, PhD, director, The Earth Institute at Columbia University

Please note that Vandana Shiva, originally scheduled to appear in this session, cancelled her appearance.

Conference closing by Nils Daulaire, MD, MPH, Global Health Council

White Ribbon Alliance for Safe Motherhood Reception and Dance Party

5–7 PM
Ambassador Ballroom

Celebrate the extraordinary efforts of dedicated advocates working to raise awareness and reduce the risks of maternal mortality. End the week on a festive note and relax with refreshments and live music.

Faculty Disclosures

Carmen Aldinger
China School Nutrition Project Produces Key Results
Research funded by World Health Organization (WHO).

Milton Amayun
Meeting the Growing Challenge of Africa's AIDS Orphans
Employed at World Vision as the Senior Technical Advisor to the Hope Initiative/Global Program on HIV/AIDS.

Franklin Broadhurst
Volcano Eruption in Goma: Avoiding a Cholera Outbreak
The Office of Foreign Disaster Assistance (OFDA) provided materials and funding to the emergency response in Goma.

Charles Chopak
Improving Food Security in Africa
Employed by Chemonics International.

Henry Koner
Tapping Market Financing to Reduce Threats to Health from Industrial Pollution
Employed by Chemonics International.

Auguste Kpognon
Voluntary Counseling and Testing Services for High-Risk Populations in Togo: Military and Youth
May mention condoms, VCT and STI services, and STI kits.

Thomas Luben
A Study of the Presence, Use and Distribution of Pesticides in the Río Jigüina Watershed, Matagalpa, Nicaragua
Mentions names of commercial pesticides.

Grace Miheso
Pharmacies: A Viable Option for Meeting Youth Reproductive Health Needs
Collaborated with Pharmaceutical Society of Kenya, Ministry of Health and the University of Nairobi for development of curriculum.

Jorge Mora
Challenges of Targeting Migrant Workers in Rural India
Employed by the François-Xavier Bagnoud US Foundation as a public health specialist. The Bill & Melinda Gates Foundation provided a grant for the project.

Larry Morgan
Increasing Rural Nepalese Incomes and Nutritional Status
Employed by Chemonics International.

Kirk Riutta
Mapping the Relationship between Population and the Environment
Project funded by USAID-OPHN.

Chris Smith
Reducing Exposure to Lead: A Critical Urban Health Problem
Employed by Chemonics International.

Roy Stacey
Food Security and HIV/AIDS
Employed by Chemonics International.

CONTINUING MEDICAL EDUCATION (CME) CREDITS

This activity has been planned and implemented in accordance with the Essentials and Standards of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of the American Public Health Association (APHA) and the Global Health Council. The APHA is accredited by the ACCME to provide continuing medical education for physicians. The APHA designates this continuing medical education activity for a maximum of 25.5 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association. Each physician should claim only those hours of credit actually spent on the activity.

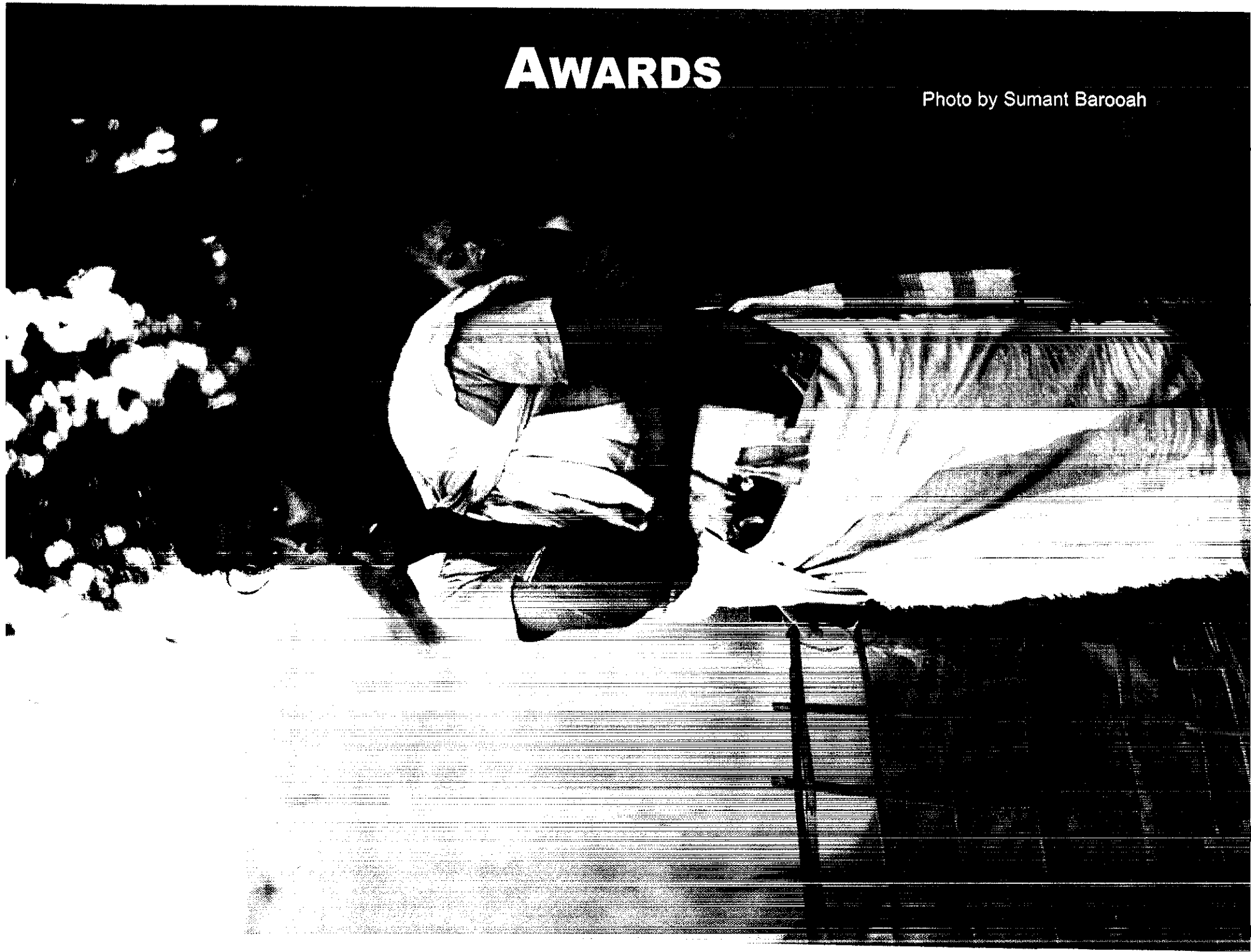
Only sessions marked in the program are eligible for continuing medical education credit hours. Participants may earn 1.0 Category 1 credit hour for each 60-minute session, 1.5 Category 1 credit hours for each 90-minute session, 2.0 Category 1 credit hours for each 2-hour session, and 3.0 Category 1 credit hours for each 3-hour workshop. A maximum of 25.5 Category 1 credits may be earned by participating in this conference.

Conference Objectives

- To define the roles of the global health community in responding to the influences of physical, economic and social environments on health
- To identify lessons learned and best practices in addressing environmental threats to health among the poor
- To increase information about and general public awareness of global health issues and how they are affected by traditional and modern environmental factors
- To enrich the work experiences of health and environmental professionals by introducing new skills and improving existing skills in advocacy, training, communications, methods, research and program development
- To provide both formal and informal opportunities for attendees to share ideas, information and experiences, and to promote alliances and networking to address global health issues.

AWARDS

Photo by Sumant Barooah



Awards Banquet Featured Speakers

MAMPHELA RAMPHELE
WORLD BANK

Dr. Mamphela Ramphele is managing director at the World Bank, responsible for the institution's human development activities, including education, health, nutrition, population and social protection. The first African to hold the position of managing director at the World Bank, Dr. Ramphele also oversees the World Bank Institute, the Bank's teaching arm, and leads the World Bank's work in information communication technology (ICT) in order to improve development effectiveness. In addition, she is responsible for the World Bank's relationship with the Group of 20.

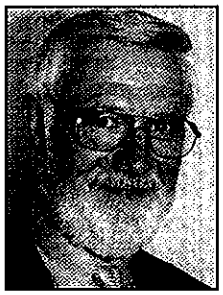
A South African-born medical doctor, Mamphela Ramphele is a former vice chancellor of the University of Cape Town. She holds a PhD in social anthropology, a BCom degree in administration, and diplomas in tropical health and hygiene and public health. As a student, she played a key role in the black consciousness movement in South Africa. As a result of her strenuous anti-apartheid activities, she was banished by the South African Government to an impoverished township from 1977 to 1984. For her professional commitment, scholarship, service to the community, leading role in raising development issues, her spearheading of projects for disadvantaged persons and her devotion to the health and social welfare of the poor people, she has received numerous prestigious national and international awards, 18 honorary doctorates and the Medal of Distinction from Barnard College. She has written many books and articles on education, health and social development for which she has received numerous prizes and awards.

CAROLE SIMPSON
NEWS ANCHOR
ABC NEWS

Carole Simpson is anchor of World News Sunday and an Emmy Award-winning senior correspondent for ABC News who reports frequently on family and social issues for the American Agenda series of World News Tonight with Peter Jennings, 20/20, Nightline and other ABC news programs and specials. She also substitutes for Peter Jennings on World News Tonight.

Ms. Simpson was one of the reporters on the critically acclaimed documentary, *Black and White in America*, and anchored three hour-long ABC News specials: *The Changing American Family*, *Public Schools in America*, and *Sex and Violence in the Media*.

In 1990, she was a member of the Nightline team in South Africa. She helped anchor ABC's live coverage of the release of Nelson Mandela from his 27-year imprisonment. *She has established several college scholarships for women and minorities pursuing careers in broadcast journalism, and in 1998, she created the Carole Simpson Leadership Institute at the African Women's Media Center in Dakar, Senegal, to train African women journalists to assume leadership roles.*



WILLIAM FOEGE
CHAIR, GLOBAL HEALTH COUNCIL BOARD OF DIRECTORS
DISTINGUISHED FELLOW, BILL & MELINDA GATES FOUNDATION

Dr. Foege is a fellow at the Bill & Melinda Gates Foundation and a professor emeritus in the Department of International Health at Emory University's Rollins School of Public Health. He is an epidemiologist, who worked in the successful campaign to eradicate smallpox in the 1970s. In 1984, several colleagues and he created the Task Force for Child Survival, a working group for the World Health Organization, UNICEF, the World Bank, UNDP and the Rockefeller Foundation. Dr. Foege also has served as the executive director of The Carter Center. He received his BA from Pacific Lutheran University, his MD from the University of Washington Medical School, and his MPH from Harvard University.

Dr. Foege has been recognized for his outstanding work in public health, especially for his instrumental part in the eradication of smallpox, and was awarded the Mary Lasker Award for Public Service in 2001.

Annual Awards Banquet Thursday, May 29, 2003

Conference participants are invited to attend the annual Awards Banquet on Thursday, May 29 at 6:30 pm in the Regency Ballroom of the Omni Shoreham Hotel. The Awards Banquet is an evening to honor those who have dedicated their lives, often at great personal risk, to improving and contributing to the field of global health.

During this celebration, the recipients of the Gates Award for Global Health, the Jonathan Mann Award for Health and Human Rights, the Best Practices in Global Health Award, the Global Health Excellence in Media Award, and the Global Health Photography Award will be honored. While the awards are given to a singular organization, team or person, each recipient represents the thousands of individuals working daily to ensure health equity and quality worldwide.

The evening begins with a champagne reception in the Exhibition Hall at 5 pm.

Dinner is served at 6:30 pm and the program, where the five annual awards administered by the Council are presented, begins at 7:10 p.m.

Black tie attire is not required for the reception or dinner. We invite all our dinner guests to attend in traditional national dress. Business attire or formal eveningwear is appropriate as well.

Please note that the Awards Banquet is a ticketed event and no admission will be made to the program without a ticket. Conference participants who have not pre-registered for the Awards Banquet may inquire about purchasing tickets for $75 at the Conference Registration Desk at the Omni Shoreham Hotel on a space-available basis. We regret that we will not be able to admit guests without tickets.

This year, there will be assigned tables for all our guests at the awards dinner and program. Council staff will be available to assist with seating. You will find your table number printed on your awards dinner ticket in your registration package. You will need to present this ticket upon entry to the dinner in the Regency Ballroom. If you have not received a ticket in your registration package and you have registered for the Awards Banquet, please check at the Conference Registration Desk.

The Gates Award for Global Health

The Bill & Melinda Gates Foundation established the Gates Award for Global Health in the amount of $1 million to recognize an organization that has made a major and lasting contribution to the field of global health. The Global Health Council administers the award process.

Any organization from any country in the world that has substantively improved the health and the lives of people in need may be nominated for the Gates Award; the organization may be a charitable institution, a private company or a public entity.

2003 Gates Award for Global Health Jurors

Jacqueline Bataringaya, MD
ActionAid's Global HIV/AIDS Coordinator
Zimbabwe

Robert Black, MD, MPH
Edgar Berman Professor and Chair, Department of International Health
Johns Hopkins University Bloomberg School of Public Health

Nils Daulaire, MD, MPH
President & CEO, Global Health Council

Carol Emerling, LLB

William Foege, MD, MPH
Presidential Distinguished Professor of International Health
Emory University Department of International Health
Distinguished Fellow, Bill & Melinda Gates Foundation

Helene Gayle, MD, MPH
Director for HIV/AIDS and TB, Bill & Melinda Gates Foundation

Luis Vincent Giay
Former Chairman, Rotary Foundation
Argentina

Joel Lamstein, SM
President, John Snow, Inc.

Afaf Meleis, PhD
Margaret Bond Smith Dean of Nursing
University of Pennsylvania School of Nursing

William Pape, MD
Founder and President, GHESKIO
Haiti

Jan Piercy
Advisor, Shorebank Corporation

Barbara Pillsbury, PhD
Vice President, International Health & Development Associates

Joe Peterson, MD
CEO, On Assignment, Inc.

Hon. Paul Rogers
Senior Partner, Hogan & Hartson

James Strickler, MD
Professor of Medicine and Dean Emeritus
Dartmouth Medical School

Louis Sullivan, MD
President Emeritus
Morehouse School of Medicine

Sen. Mechai Viravaidaya
Founder and President
Population and Community Development Association
Thailand

The 2003 Gates Award for Global Health recipient will be announced at the Annual Awards Banquet on Thursday, May 29th.

Jonathan Mann

Jonathan Mann Award for Health and Human Rights

Jonathan Mann was a voice of conscience and a tireless advocate for people around the world who have been denied the basic rights of access to the necessities required for their human health and dignity. Dr. Mann was killed, along with his wife Dr. Mary Lou Clements-Mann, in the crash of Swissair flight 111 in September 1998. He was a crusader against AIDS and a champion for human rights.

As an epidemiologist in Africa, he could clearly see the connection between poverty and ill health. He played a major role in focusing public attention on the fact that prejudice and discrimination were helping to drive and spread the AIDS epidemic. He realized early on that fueling the epidemic was not simply the virus itself, but discrimination against those at risk of infection.

The Jonathan Mann Award for Global Health and Human Rights has been established to honor this remarkable individual and call continued attention to the vital links between health and human rights.

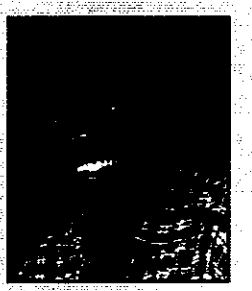
The Jonathan Mann Award is bestowed annually on one or several individuals who carry out a commitment to health and human rights, often at great personal danger. The $20,000 award is jointly overseen by three partners, Doctors of the World, François-Xavier Bagnoud Foundation and the Global Health Council, along with support from other contributors including John Snow, Inc. and an anonymous donor.

This year's award is being shared by two tireless advocates in the fight against HIV/AIDS — Zackie Achmat of Treatment Action Campaign in South Africa and Dr. Frenk Guni, former executive director of Zimbabwe Network of People Living with HIV/AIDS.

Zackie Achmat, through his work with the Treatment Action Campaign (TAC), has worked tirelessly to raise awareness about HIV/AIDS throughout the spectrum of South African society. Mr. Achmat has used his own HIV+ condition as a platform upon which to advocate for equity and illustrate that health care is a basic human right. His private insurance would pay for the ARV treatment he needs, but he refuses to take any treatment that isn't available to everyone. He is a man willing to die for his convictions that all should have an equal right to care. His unwavering tenacity has kept this issue on the forefront of the South African Government's agenda.

Mr. Achmat is one of the founders of TAC. It was on December 10, 1998, International Human Rights Day, that a group of approximately 15 people protested on the steps of St George's Cathedral in Cape Town to demand medical treatment for people living with the virus that causes AIDS. The group included people with HIV, a medical student, a 66-year-old grandmother, a former human rights commissioner and a selection of others determined to draw attention to the unnecessary suffering and death caused by the untreated epidemic. Passers-by were surprised. Not many of them knew that you could treat AIDS. They didn't realize that AIDS medications were freely available in Western countries.

By the end of the day, the group had collected more than 1,000 signatures calling on the government to develop a treatment plan for all people living with HIV, and TAC was born.



Dr. Frenk Guni is a founding member of the Zimbabwe Network of People Living with HIV/AIDS (ZNNP+), serving the development and growth of the network since 1992. The network serves more than one million HIV-positive people across the country. As an NGO liaison, he helped the government establish the AIDS Levy in Zimbabawe. The AIDS Levy is a tax whose proceeds are to be used to serve HIV/AIDS programs in Zimbabwe, including services to support groups of people living with HIV/AIDS. By supporting PWA gay men and lesbians in Zimbabwe, Dr. Guni's work ran counter to governmental policies and directives. Refusing government orders to distribute AIDS resources as political favors for the ruling party, he was forced to leave the country in November 2001.

Dr. Guni is passionate about people and their right to health and dignity. He displayed courage and honor in standing up for thousands of Zimbabweans whose life and dignity were at the mercy of political games. Dr. Guni is currently in the U.S., where he is receiving medical treatment for lymphoma and HIV.

For more information on Zackie Achmat and the Treatment Action Campaign, please visit their website at http://www.tac.org.za. For more information on Zimbabwe Network of People Living with HIV/AIDS (ZNNP+), please visit http://www.enda.sn/africaso.org/zimbabwenational-net.html.

The Global Health Excellence in Media Award

Paula Bock

The Global Health Council is pleased to present the Global Health Excellence in Media Award to **Paula Bock** of The *Seattle Times Sunday Magazine* for her article, "In Her Mother's Shoes," published December 1, 2002. Ms. Bock is a staff writer for the *Seattle Times Sunday Magazine.*

In sub-Saharan Africa, 2.3 million people died of AIDS just last year, leaving countless children alone and at risk for the disease. "In Her Mother's Shoes" is a story told in the most personal terms, the title a reference to Martha, one of some 11 million AIDS orphans in sub-Saharan Africa. Paula and photographer Betty Udesen met 24-year-old Ruth, her two children, 4 and almost 6 years old, and Ruth's mother on their first day in Zimbabwe. The very next day Ruth was dead. Her funeral was the eighth that day in the village. Her story instructs us on the devastation AIDS is causing and provides us with some means to help make a difference.

Before joining the *Times* in 1990, Paula wrote about civil rights and the disadvantaged for the *Patriot Ledger* in Quincy, MA, and she has freelanced for the *Boston Globe, Boston Phoenix, Hartford Courant, Florida Sun-Sentinel* and *Los Angeles Times.* Her essay about mission and meaning in journalism was recently published in *Values and Craft of American Journalism: Essays from the Poynter Institute.*

The Global Health Excellence in Media Award is given each year to a media outlet or journalist (print, electronic or visual) who has in the prior year most effectively captured the essence of a major issue in global health and conveyed it to a broad audience. The jury consists of an independent panel of noted journalists.

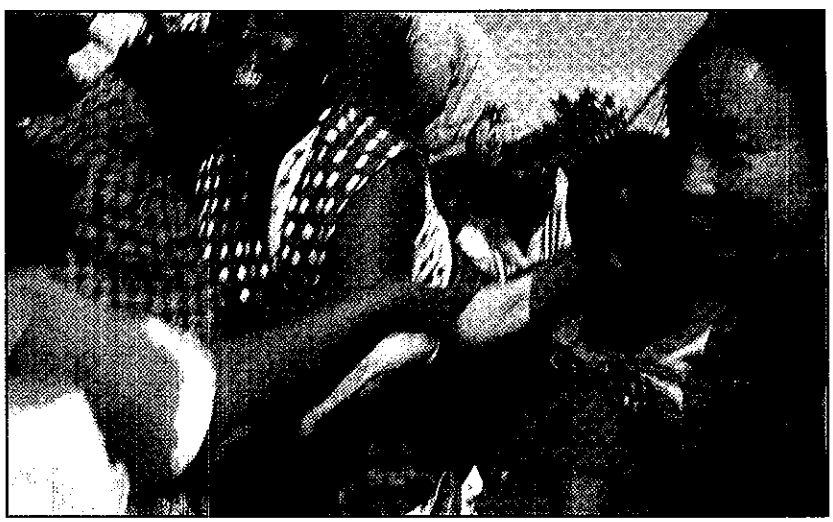


Photo by Betty Udesen - Seattle Times Sunday Magazine

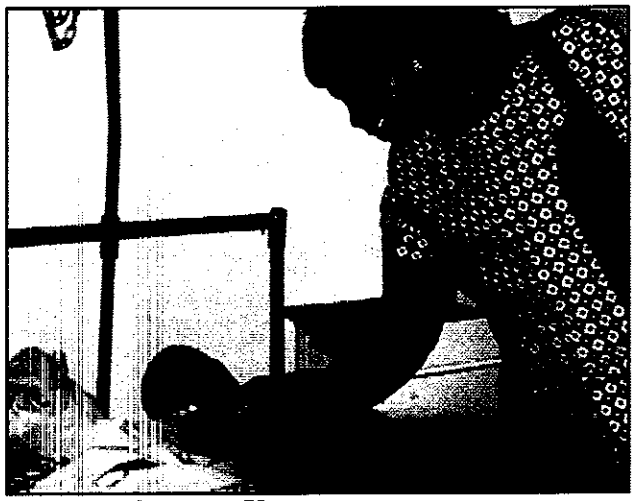
Paula Bock on assignment in sub-Saharan Africa.

The Global Health Council recognizes the vital role played by the media in informing the public as well as decision-makers, and seeks through this award to highlight the important contributions to understanding and action made by the winner of the award.

Some copies of the complete article are available at the Global Health Council's booth in the Exhibition Hall. To read the complete story online, please visit http://seattletimes.nwsource.com/news/nationworld/aids/01.html.

Best Practices in Global Health Award

This year, the Global Health Council is honored to present this award to a remarkable individual, Professor **Angela J. Sawyerr-Kamara**, founder and director of the Regional Prevention of Maternal Mortality Program (RPMM), based in Ghana with programs in 20 African countries.



Angela J. Sawyerr-Kamara

The award for Best Practices in Global Health is given to celebrate and highlight the efforts of an individual in the field dedicated to improving the health of disadvantaged and disenfranchised populations, and to recognize programs that effectively demonstrate the link between health, poverty and development. Recipients of the award are selected for their ability to demonstrate measurable results in the field, as well as the ability and expertise to share, inspire and extend best practices for improving health.

Angela Kamara leads a network of multidisciplinary teams dedicated to reducing maternal mortality in Africa. Some of the highest rates of maternal death in the world are in Africa; limited availability and quality of care give a sub-Saharan African woman an incredible 1 in 13 chance of dying from pregnancy- and delivery-related causes. The RPMM network responds directly to this problem with effective, creative and sustainable programs.

The RPMM network uses the Three Delay Model (first delay–delay in seeking care; second delay–delay in reaching a medical facility with comprehensive obstetric care; third delay–delay in receiving quality care) for preventing maternal death. The teams start their program response with the third delay — ensuring good quality care once the women reaches the facility — because, as Angela Kamara says, "you have to first prepare the house before you invite the guests." The teams are multidisciplinary, composed of community physicians, nurse-midwives, obstetricians, social scientists, anesthetists and journalists. Increasing the skills and working in full collaboration with staff of the facilities and communities in which the team is active is a hallmark of RPMM efforts, since a primary function is capacity building. Finally, all members of the RPMM teams are from the countries in which the network is active, in order to establish sustainability of the program.

Professor Kamara and RPMM's success in ensuring good-quality emergency obstetric care in Ministry of Health facilities serves as a model to programs in any country. RPMM encourages an environment in which community members and facility staff feel responsible for and capable of delivering quality care. RPMM promotes partnerships among public, private, NGO, local and international constituents that move the RPMM purpose forward. Angela Kamara and RPMM promote their model of community resource-building even in very difficult places, including war-affected countries such as Liberia, Sierra Leone and Angola.

But what makes RPMM, and Angela Kamara's leadership, stand out from many other excellent efforts around the world is that it is a South-South collaboration. There is a role to play in Africa for professionals from the North and other regions, but RPMM shows us another model. This model relies on Africans advising Africans, and it works beautifully. Maternal death is not a "women's" health problem. It is a community problem that requires involvement and sincere commitment on the parts of many individuals and groups.

For more information on Angela Kamara and the Regional Prevention of Maternal Mortality Program (RPMM), please visit their website at www.rpmm.org

Global Health 2003 Photography Award

The 2003 Photography Award winner is Nitin Khatri.

The Global Health Council is pleased to present the Global Health Photography Award to Nitin Khatri. A native of India, Mr. Khatri has received international acclaim for his work. He is a native of Indore and has a keen interest in environmental issues.

Photographs used throughout the final program are submissions to the Global Health Council's photography contest.

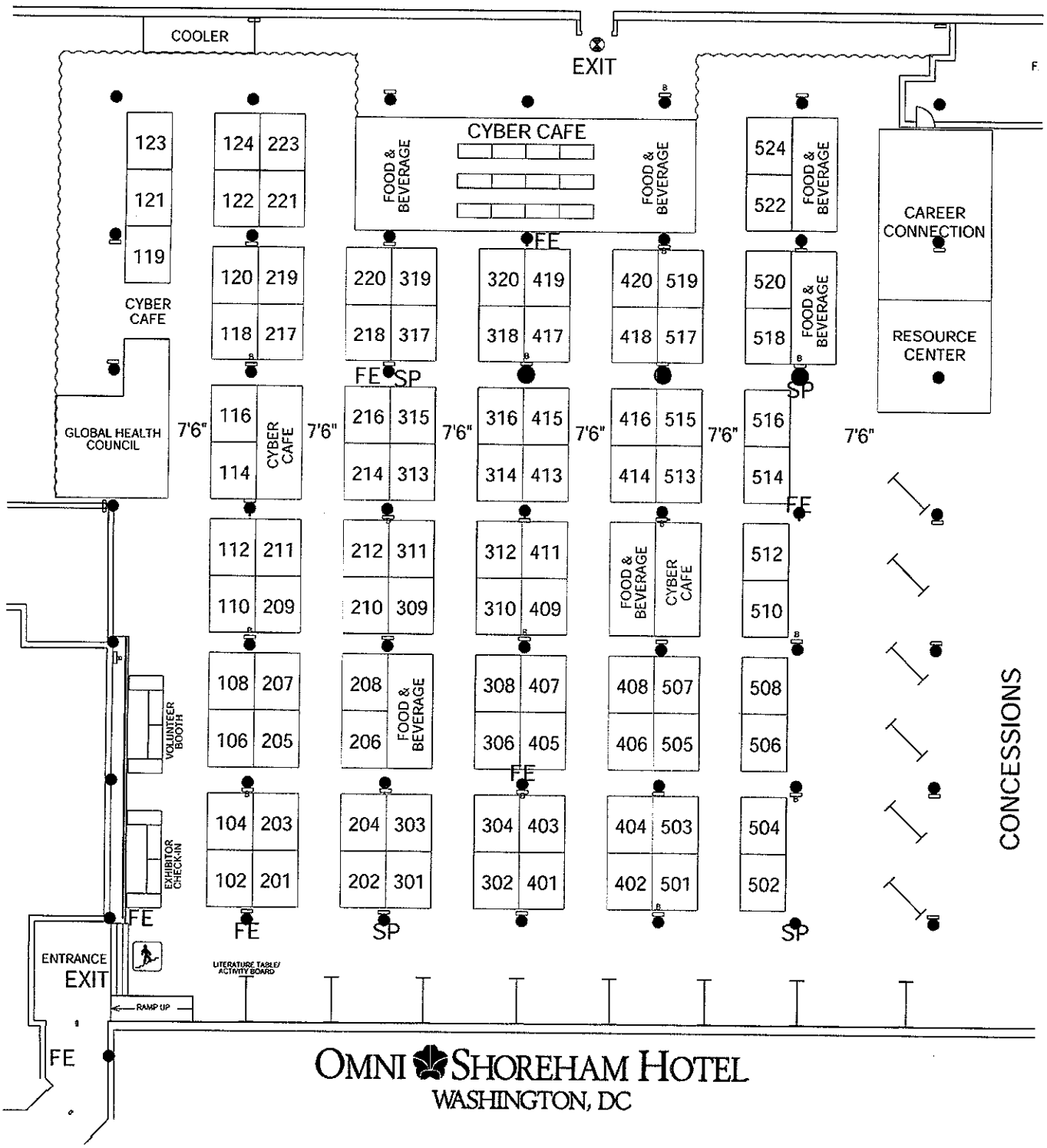
EXHIBITORS

Photo by Noah Friedman-Rudorsky

Exhibition Hall

Global Health Council

May 27 – 30, 2003
Omni Shoreham Hotel
Exhibition Hall
Washington, D.C.



Exhibitors

Abt Associates, Partners for Health Reform*plus*
Booth 409

Abt Associates, Inc. leads USAID's flagship health policy and systems strengthening project, Partners for Health Reform*plus* (PHR*plus*). PHR*plus* is improving health policy, financing and information in more than thirty countries. With field offices in Latin America, Africa, the Middle East, Eastern Europe and the former Soviet Union, we are strengthening infectious disease surveillance, increasing capacity to manage HIV/AIDS treatment, improving vaccine programs, and supporting community-based health insurance efforts to help those at greatest risk – women, children and the poor.

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Website: www.abtassociates.com

Academy for Educational Development
Booths 517-519

Founded in 1961, Academy for Educational Development (AED) is one of the world's foremost nonprofit human and social development organizations. It operates more than 250 programs worldwide to help people improve their lives through better health, education and economic opportunities. AED's mission encompasses global leadership in the major areas of human development – education, the environment, health, civil society and governance, gender, and youth and leadership development – and how they intersect. At the heart of all our programs is an emphasis on generating and applying knowledge to better people's ability to contribute to the well-being of their families and communities. In the United States and nearly forty countries in Africa, Asia, Latin America and the Middle East, AED programs aim to strengthen individual, community, institutional and government actions to assure the health of vulnerable populations. Activities include policy dialogue, behavior change strategies, building the capacity of local institutions and communities, and partnerships with the commercial sector. AED is implementing programs to combat the spread of HIV/AIDS, malaria and infectious diseases; improve food security and lower malnutrition rates; and promote healthy lifestyles. Programs are managed through the AED Center on AIDS and Community Health, the AED Center for Applied Behavioral and Evaluation Research, the AED Center for Family Health, the AED Center for Health Policy and Capacity Development, the AED Center for Nutrition, and the AED Center for Social Marketing and Behavior Change. Special global health programs include: Food Security and Poverty Alleviation, Mother-to-Child Transmission of HIV and the Private Enterprise Initiative.

Renata Seidel
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Adventist Development Relief Agency (ADRA) International
Booth 308

The Adventist Development and Relief Agency (ADRA) International is an independent humanitarian agency established in 1984 by the Seventh-Day Adventist Church for the specific purpose of providing individual and community development and disaster relief. The Economic and Social Council of the United Nations (ECOSOC) granted ADRA general consultative status in 1997. With a presence in more than 120 countries, ADRA assisted more than 15 million people in 2002 and provided development and relief assistance valued at $102 million. Through a variety of projects, ADRA strives to support the dignity that is inherent in each person. Committed to improving quality in human life, ADRA helps people in need, especially women, children and senior citizens who are often most vulnerable. ADRA serves people without regard to their ethnic, political or religious association. ADRA's development and relief work is divided among five core portfolio activities: Food Security, Economic Development, Primary Health, Disaster Preparedness and Response, and Basic Education. ADRA addresses basic health care issues in developing countries through various programs including mother/child health, family planning, HIV/AIDS and maternal mortality. Most often health programs focus on activities such as improving access to clean, potable water, sanitation systems, immunizations and nutritional intake. ADRA is using the power of education to fight HIV/AIDS in Africa. ADRA's HIV/AIDS Education and Awareness program helps instruct communities about the cause and prevention of HIV/AIDS and teaches adults and children how to care for family and friends with the disease. In addition, ADRA is providing Life Skills, which empower youth with tools to make positive, informed choices.

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African Youth Alliance
Booth 112

The United Nations Population Fund (UNFPA), the Program for Appropriate Technology in Health (PATH) and Pathfinder International (PI) have come together to form a unique partnership and a five-year program, the African Youth Alliance (AYA). AYA is an exciting, innovative and field-driven program that aims to improve the sexual and reproductive health of young people in Botswana, Ghana, Tanzania and Uganda. AYA is now in its third year and is already making a sub-

stantial difference in the lives of young people in these countries through dynamic, results-oriented partnerships with governmental institutions, nongovernmental organizations (NGOs), and community-based and youth-serving organizations in the AYA countries. Partnerships improve the quality and increase the scale and effectiveness of programs and services for young people. Through its work, AYA hopes to enhance an appreciation for viewing youth as our world's greatest asset and hope for the future. AYA focuses on reaching young people between the ages of ten and twenty-four, with an emphasis on ten to nineteen-year-olds. Specifically, AYA's goal is to help the four countries: reduce rates of HIV/AIDS, other sexually transmitted infections, and pregnancy among young people; promote the delay of sexual debut and, among sexually active youth, the use of condoms and other contraceptives; and eliminate harmful traditional practices and forced and coerced sex. AYA is funded by a visionary grant from the Bill & Melinda Gates Foundation through the U.S. Committee for the United Nations Population Fund.

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American College of Nurse-Midwives Booth 418

The American College of Nurse-Midwives (ACNM) is the oldest women's health care organization in the U.S. ACNM provides research, accredits midwifery education programs, establishes clinical practice standards, and creates liaisons with government agencies and members of Congress.

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American International Health Alliance Booth 420

The American International Health Alliance (AIHA) establishes and manages community-based partnerships between health care institutions in the United States and their counterparts in Central and Eastern Europe and Eurasia. Through regional programs focusing on issues such as primary health care, women and children's health, preventing mother-to-child transmission of HIV/AIDS, neonatal resuscitation, nursing, emergency medicine and disaster preparedness, infection control, and health professions management and education, AIHA and its partners are contributing not only to health systems reform in some twenty-two nations, but also helping to improve the health status of communities and individuals.

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American Public Health Association (APHA) – International Health Section Booth 403

The American Public Health Association (APHA) is the oldest and largest organization of public health professionals in the world, representing about 50,000 specialists from over fifty occupations of public health. Throughout the 126-year history of this membership organization it has been in the forefront of influencing policies and setting priorities to prevent disease and promote health. The International Health Section, which was established in 1976, has grown into a community of 1500 APHA members who have a primary interest in international and global health. The Section works to share knowledge and experience with their peers, develop new techniques, advocate for good policies and contribute to scientific knowledge. The International Health Section communicates with its members via a newsletter that is accessible to the public at our website: www.apha-ih.org. The Section's mid-year meeting is held at the time of the Global Health Council annual conference. The Section provides a rich program of about 150 scientific presentations at the APHA annual meeting, usually held in November. A policy and advocacy committee prepares policy recommendations and resolutions of interest to the constituency. The Section also sponsors a Working Group on Community-Based Primary Health Care. APHA enjoys a close working relationship with the Global Health Council as well as with other professional organizations involved in global health, such as the World Federation of Public Health Associations.

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Association Book Exhibit Booth 401

New and current titles of professional interest from leading publishers are available for sale. Stop by for a free catalog.

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Exhibitors

Averting Maternal Death and Disability (AMDD) Program, Columbia University
Booth 514

The Averting Maternal Death and Disability (AMDD) Program was launched in 1999 at Columbia University's Heilbrunn Department for Population and Family Health, Mailman School of Public Health, to work with developing countries on improving the availability, quality and utilization of Emergency Obstetric Care (EmOC). The basic premise of the AMDD program is that most of the obstetric complications that lead to maternal death can neither be predicted nor prevented, but the vast majority of women can be saved through prompt treatment. AMDD addresses three inter-connected areas: technical know-how, management capacity and respect for human rights. AMDD has established partnerships with organizations that already have field operations. These partners are now implementing over fifty-five AMDD-supported projects in thirty-nine countries: United Nations Children's Fund (UNICEF) – projects in Bangladesh, Bhutan, India, Nepal, Pakistan and Sri Lanka; United Nations Population Fund (UNFPA) – projects in India, Morocco, Mozambique and Nicaragua; Regional Prevention of Maternal Mortality (RPMM) Network – teams and projects in nineteen sub-Saharan African countries; CARE – projects in Ethiopia, Rwanda, Tanzania, Peru and Tajikistan; Save the Children – projects in Mali and Vietnam; Reproductive Health for Refugees (RHR) Consortium – projects in twelve countries. Among the key Program tools are the process indicators developed at Columbia University and issued by UNICEF, the World Health Organization (WHO) and UNFPA. AMDD technical partners include: Family Health International, John Snow International, Indian Institute of Management at Ahmedabad (IIMA), EngenderHealth and JHPIEGO. The AMDD Program is funded by the Bill & Melinda Gates Foundation.

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The Basics II Project
Booth 402

BASICS II (Basic Support for Institutionalizing Child Survival) is USAID's flagship project for child health. BASICS II focuses on immunization, nutrition and growth promotion, perinatal and neonatal health, and Community-Integrated Management of Childhood Illness. Improvements in these technical areas promise the greatest reductions in child mortality, and each area engages in activities that promote a healthy environment. Results are achieved through technical assistance in policy development and advocacy, health systems strengthening, communications strategies, and improved delivery of health services and products in homes, communities and health facilities. The Project aims to achieve impact on child survival on all levels: community, district and national levels; and, through technical leadership, BASICS II advances state-of-the-art child survival policies and programming regionally and globally. BASICS II has worked actively in sixteen countries in Africa, Asia and the Near East, and Latin America. The Project draws on highly experienced technical specialists from its partners (Academy for Educational Development, John Snow, Inc. and Management Sciences for Health) and subcontractors (Emory University, Johns Hopkins University, The Manoff Group, Inc., PATH, Save the Children Federation, Inc., and TSL). These experts are complemented by specialists in other critical program areas, including communication and behavior change, drug management and injection safety. BASICS II transfers its expertise and lessons learned strategically through workshops, networks, electronic and Web applications, and utilizes other strategies to ensure that project success stories are analyzed, shared and used to influence global health and development priorities.

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Ben-Gurion University of the Negev MD Program in International Health and Medicine in collaboration with Columbia University Health Sciences
Booth 209

In collaboration with Columbia University's Health Sciences Division, Ben-Gurion University of the Negev offers a unique MD Program in International Health and Medicine. Students are trained to become physicians who can work with diverse populations and address the complex factors that affect global health. The program accepts qualified students of all nationalities, offers early clinical work and requires clerkships at approved international sites. Current clerkship locations include India, Ethiopia, Kenya and Nepal.

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Boston University International Health Department
Booth 312

The Department of International Health is the focal point for international health activities at Boston University School of Public Health. Our mission is to work, using the tools, approaches and skills of public health, to reduce or eliminate suffering around the world – whether due

to infectious diseases such as malaria, AIDS, tuberculosis or diarrhea; or to malnutrition, obstructed labor or other diseases of poverty; or to human misbehavior and natural events that produce trauma, conflict, dislocation and genocide. Over the past two decades, more than 2,500 public health practitioners from over 140 countries have participated in the Department's unique, intensive certificate programs. Each fall, spring and summer, we offer these twelve-week programs focused on: Management and Finance; Managing Disasters and Complex Emergencies; and International Health Contexts, Methods and Controversies. The Department also currently has 180 students in the Master of Public Health degree program concentrating in International Health. A unique feature of the IH concentration is its Writing Program, which encourages students to become forceful, effective public health writers. The work of the Department is augmented by its close relationship to the Center for International Health and Development that brings a worldwide reputation for excellence in applied research. The Center carries out applied, policy- and program-relevant research on critical questions of public health in developing countries. The Department and Center are part of Boston University School of Public Health, a vibrant institution dedicated to excellence in education, research and service locally, nationally and internationally. A new DrPH program (including International Health) is set to begin in 2004.

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Catholic Medical Mission Board (CMMB)
Booth 304

Celebrating its seventy-fifth anniversary in 2003, Catholic Medical Mission Board (CMMB) is the leading U.S.-based Catholic charity that focuses exclusively on providing health care to people in need worldwide, particularly that which improves the well-being of women and children. In fiscal year 2002, total support to CMMB reached over $97 million. That support allowed CMMB to launch major programs in the areas of primary health care, infectious disease prevention and control, and provide more than $80 million in medicines and medical supplies to more than sixty countries worldwide.

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CEDPA
Booth 214

The Centre for Development and Population Activities (CEDPA) is an international development organization working to empower women. Founded in 1975, CEDPA has provided services to millions of women through partnerships with more than 100 organizations in 150 countries. CEDPA's unique and successful approach to development has its foundation in the belief that a woman's ability to access education and economic opportunities and to participate in civic life is inextricably linked to her ability to access quality reproductive health services, including family planning. To sustain the services she needs and provide life-enriching skills, CEDPA strengthens community organizations that provide those choices and other vital support. Leaders of these groups, now more than five thousand strong, form a powerful global CEDPA network. Together, we advocate at national and global levels to bring about lasting change for women. CEDPA is headquartered in Washington, DC, and has offices in Egypt, Guatemala, India, Mali, Nepal, Nigeria, Russia, Senegal and South Africa.

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Center for the Evaluative Clinical Sciences at Dartmouth
Booth 204

The Center for the Evaluative Clinical Sciences offers three graduate degree programs: a Master of Public Health (MPH), a Master of Science (MS), and a Doctor of Philosophy (PhD) in the Evaluative Clinical Sciences. The MPH and MS programs build upon a rigorous core curriculum that provides an understanding of the challenges facing the U.S. health care system and a firm grounding in the skills required to measure, organize and improve health and health care. The PhD program offers in-depth, multidisciplinary training in the conduct of research and teaching in the areas of special expertise at the CECS. Concentrations include Health Policy, Biostatistics and Epidemiology, Quality Improvement of Health Care, or Health Care Decision Making. These degree programs (as well as a postdoctoral program) are geared toward physicians, health care administrators, health policy-makers and others interested in the disciplines of the evaluative clinical sciences and their application to current issues in the public health and health care systems.

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Centers for Disease Control and Prevention – Division of Diabetes Translation
Booth 116

The Division of Diabetes Translation at the Centers for Disease Control and Prevention is the leading federal

agency for translating diabetes research findings into community level programs that reduce morbidity, mortality and cost associated with diabetes.

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Centers for Disease Control and Prevention – Division of Reproductive Health
Booth 120

Centers for Disease Control and Prevention – Office of Global Health
Booth 114

The mission of the Center for Disease Control and Prevention's (CDC) Office of Global Health is to improve health worldwide by providing leadership, coordination and support for CDC's global health activities in collaboration with CDC's global health partners. Our major activities include: providing leadership in the development of cross-cutting global health programs and policies at CDC; working to expand CDC's capacity to carry out global health activities through innovative public and private partnerships; and helping to coordinate and support CDC global health programs through service, rational policy development and mobilization of resources. CDC's Global Health Exhibit showcases the global health work across CDC. On display will be program information and publications from a number of CDC's Centers, Institutes and Offices.

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Chemonics International
Booth 507

Chemonics addresses health issues through a comprehensive multisectoral approach. Health and development are inextricably linked and strong, healthy populations are key to economic growth. From governance to the environment, humanitarian assistance and health, for the past twenty-seven years Chemonics has provided technical and management services worldwide to raise the quality of living. Since our founding in 1975, we have designed, managed and evaluated complex, multidisciplinary development projects in 130 developing countries. Chemonics' International Health Group emphasizes local capacity building and institutional strengthening to: enhance private sector delivery of health services, including strengthening private clinics and pharmacies; build public private partnerships, including privatizing hospitals; develop and evaluate workplace programs in HIV/AIDS and TB; support decentralization by preparing local governments and communities to plan and oversee decentralized health services; integrate health into multisectoral activities, such as promoting nutrition through agricultural development projects; develop customized public communications and education programs; leverage technology and the Internet to advance education, behavior change and service delivery; and oversee and manage health-focused grants.

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Christian Connections for International Health
Booth 302

Christian Connections for International Health (CCIH) is a member association of Christian organizations and individuals promoting international health and wholeness from a Christian perspective through information exchange, networking, advocacy, research, fellowship and partnership building. Services include: journal, *The CCIH Forum*; annual retreat/conference immediately before the Global Health Council conference; listserv – to join, send a blank email to the email address: CCIH-News-subscribe@yahoogroups.com; website, www.ccih.org; research on compelling issues in international health from a Christian perspective (e.g., the future of Christian hospitals, and Christian responses to AIDS, malaria and TB.) CCIH participates in the Global Health Council, APHA, and other international health professional organizations, and represents the health ministries of churches and missions in developing countries to the larger international health community. Major activities include: conference *Challenges for the Church: AIDS, Malaria, and TB* (abstracts on www.ccih.org); advocating for policies favorable to faith-based organizations in the Global Fund to Fight AIDS, Tuberculosis and Malaria, including a survey; disseminating information about the Ugandan success in reducing HIV prevalence, emphasizing delayed sexual debut and partner reduction, and the role of faith-based organizations in producing these primary behavioral changes; retreat/conference, *Health and Healing within a Faith Environment;* initiated process for improved monitoring and evaluation by faith-based organizations; published journal issue on AIDS, malaria, TB; bibliography of Christian publications on AIDS, malaria and TB; brochure *Christian Responses to AIDS, Malaria, and TB*; and compendium of good Christian projects on AIDS, malaria and TB.

Ray Martin
Christian Connections for International Health

Exhibitors

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Commercial Market Strategies
Booth 306

Commercial Market Strategies (CMS) is a USAID-funded project. We work to improve health by expanding the role of the private and commercial sectors in the delivery of quality reproductive health care and family planning in developing countries. CMS programs and initiatives combine social marketing, corporate social responsibility, NGO sustainability, provider networks, health care financing and policy change. The CMS project is implemented by a consortium of leading-edge organizations in the areas of reproductive health and family planning, social marketing and research: Deloitte Touche Tohmatsu (prime contractor), Abt Associates and Population Services International.

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Counterpart International
Booth 122

Founded in 1965, Counterpart International is a diverse, nonprofit, international development organization dedicated to helping people in need – often when they need help the most. Counterpart has worked in the Pacific, the republics of the former Soviet Union, and other regions in the areas of community mobilization, partnership building and training creating sustainable benefits for communities. Since 1996, Counterpart has implemented three USAID Child Survival Program grants in Vanuatu, Kiribati and the Solomon Islands. Today the organization is implementing two four-year Child Survival Programs funded by USAID in Uzbekistan and India in partnership with local NGOs and the MOH. Both programs focus on reducing infant mortality by emphasizing the need for increased awareness of pneumonia and diarrhea case management and nutrition among mothers and other caretakers, incorporating behavior change communication techniques. Our USAID-funded Maternal and Child Health initiative in Turkmenistan also reflects our emphasis on capacity building, enabling health NGOs to better implement maternal and child health initiatives at the community level. In Vietnam, Counterpart is collaborating with the University of Washington/Harborview and the Vietnamese Ministry of Health to strengthen Emergency Medical Service programs. We are adapting our programming to meet a growing need for innovative HIV/AIDS programs in countries including Ukraine, India and Zimbabwe. Since 1998, Counterpart Alliance for Partnership (CAP) in Ukraine has been one of the foremost small grants and technical assistance programs working with NGOs in HIV/AIDS prevention and reproductive health in the Newly Independent States of Central Asia.

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Development Alternatives, Inc. - HIV/AIDS Response Team (HART)
Booth 512

HIV/AIDS is among the greatest challenges to sustainable economic development today. No country or region is immune. In countries with high prevalence rates, HIV/AIDS undermines the economic fabric of societies, fragmenting families, livelihoods and economic sectors and undermining ongoing development efforts. The HIV/AIDS Response Team (HART) at Development Alternatives, Inc. (DAI) recognizes that HIV/AIDS requires innovative and broad-based responses to complement and reinforce public health measures. DAI brings three decades of successful economic and civil society development to the fight against HIV/AIDS. Our services include strategic planning, program design, project management, monitoring and evaluation, institutional capacity building and research. Using a collaborative and consensus-building process, we bring together stakeholders across as well as within sectors. Until recently, most interventions and most HIV-related training focused on health services and prevention, treatment and care. Now, as the impact of the epidemic is felt more widely, calls are growing for expanded, multisectoral responses. HART adapts successful techniques for improving economic livelihoods to the economic realities created by HIV/AIDS. Key areas of intervention are enterprise development and microfinance, natural resource management, and agriculture and food security. HART designs and implements training seminars for public health practitioners, who are often at the front-line responding to HIV/AIDS. These seminars introduce public health professionals to a range of economic development concepts and practices. HART builds partnerships across a range of solutions, each of which brings different interests, networks and resources to the fight against HIV/AIDS.

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Environmental Health Project
Booth 506

The Environmental Health Project (EHP) began a second five-year contract (EHP II) in June 1999, under the direction of the U.S. Agency for International Development, Bureau for Global Health, Office of Health, Infectious Diseases and Nutrition (USAID/GH/HIDN). EHP works in partnership with other USAID pro-

jects, UN and international agencies, private voluntary organizations (PVOs) and nongovernmental organizations (NGOs) to contribute to prevention of childhood diarrhea, malaria and other infectious diseases through environmentally related prevention measures. EHP's strength is based on over twenty years of program history starting with the Water and Sanitation for Health (WASH) project. EHP strives to provide global leadership in the development, implementation and promotion of new and improved, cost-effective environmental health interventions. The project: provides leadership and field support in diarrheal disease prevention through hygiene improvement (an integrated approach combining access to technology, such as water systems and sanitation facilities; hygiene promotion through behavior and social change; and enabling environments through policy improvement, public-private partnerships and institutional strengthening); helps ministries of health improve control programs for malaria and other vector-borne diseases by providing technical assistance and improved tools for surveillance, vector control and operations research on effectiveness of integrated vector management; assists nongovernmental organizations (NGOs) and other groups working in health, population and the environment (natural resource management) to link and integrate delivery approaches and activities; and provides technical assistance in improving urban health and other cross-cutting capabilities such as developing and validating indicators and data collection methods.

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Family Care International Booth 221

Family Care International (FCI) is dedicated to improving women's sexual and reproductive health and rights in developing countries, with a special emphasis on making pregnancy and childbirth safer. FCI works to advance the comprehensive, women-centered approach to reproductive health and sexual health, which has been endorsed by almost every country in the world at UN conferences over the past decade. FCI addresses a range of urgent health issues, including maternal health, adolescent sexual and reproductive health, family planning, unsafe abortion and violence against women. FCI's activities include: conducting global advocacy and information-sharing; providing technical assistance in Africa (English and French-speaking), Latin America and the Caribbean; developing guidelines, training materials and other information tools. FCI also serves as the global secretariat for the Inter-Agency Group for Safe Motherhood (IAG), a consortium of United Nations agencies and nongovernmental organizations working to improve maternal and newborn survival and well-being by promoting and supporting the implementation of cost-effective interventions in the developing world. The IAG carries out policy support and disseminates best practices and other information among policy-makers, program managers and other stakeholders worldwide.

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Family Health and AIDS Project, USAID/West Africa Regional Program (Santé Familiale et Prévention du SIDA, (SFPS) Booths 314-316

The Family Health and AIDS Project (FHA) is a West and Central African (WCA) regional initiative funded by USAID under the West Africa Regional Program (WARP). Over the last eight years of this project, JHPIEGO has led five U.S. agencies that have cooperated in six technical areas: JHPIEGO (Service Delivery and Training), JHU/CCP (Behavior Change and Communications), PSI (Social Marketing), Tulane (Operations Research) and FHI (HIV/AIDS). The FHA project sought to increase sustainable use of select Reproductive Health, STI/HIV/AIDS and Child Survival services and/or products in WCA by augmenting all of the following: access to quality services and products; advocacy for action in HIV/AIDS, Maternal Health & Child Survival; public, private and nonprofit capacity for health policy, program development and implementation in the region; and partner collaboration for transparent and efficient use of resources for developing and implementing health policies and programs. In 1995, FHA was launched in four demonstration countries: Burkina Faso, Cameroon, Côte d'Ivoire and Togo. Since 2000, the FHA project disseminated and encouraged adoption of tools and approaches in eighteen WCA countries. The FHA project addressed trans-national health problems in West and Central Africa and helped coordination efforts between countries. The regional approach used in the last three years of the project helped standardize cross-border health program strategies. This was a vital accomplishment, given the high mobility of WCA populations. The FHA Project is recognized as a principal player in family planning throughout West and Central Africa.

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Family Health International Booths 210-212

Founded in 1971, Family Health International (FHI) is a private, nonprofit organization with a mission to improve lives worldwide through a highly diversified program of research, education and services in family health. FHI emphasizes the development of public health strategies and local capacity to respond to the AIDS pandemic, other sexually transmitted infections, unintended pregnancies and related reproductive

health concerns of individuals and communities. FHI helps assure the availability of effective, safe, acceptable and affordable contraceptive products, methods and services. With an emphasis on developing country programs, FHI responds to many of the world's most vulnerable groups by promoting better access to quality services and to a range of contraceptive choices. FHI also designs, manages and evaluates international HIV/AIDS-related programs that are broad in scope, encompassing prevention as well as care and support services for people living with or affected by HIV/AIDS. FHI conducts research to evaluate new approaches for reducing viral spread. FHI's programs and research explore issues at the interface of HIV/AIDS and reproductive health, including dual protection and other contraception in HIV settings. FHI has a staff of over 800 and manages programs in more than seventy countries through two interacting institutes – the Institute for Family Health and the Institute for HIV/AIDS. FHI has its headquarters in North Carolina and an office near Washington, DC, as well as regional centers in Bangkok and Nairobi and local offices in more than thirty other countries.

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Fogarty International Center, NIH
Booth 205

The Fogarty International Center (FIC) promotes and supports scientific discovery internationally to reduce disparities in global health. Established in 1968, the FIC of today works through twenty-five programs involving U.S. universities and foreign partners to advance critical lines of research and to train the next generation of scientists. FIC's work in AIDS, maternal and child health, environmental health, the linkages between health, economic development and environmental degradation, and tobacco use prevention – all illustrative examples of FIC's program areas – are critical components of NIH and DHHS efforts to tackle major global health threats. Additional information on FIC may be found at http://www.fic.nih.gov, including information on commemorative events in 2003 to mark the thirty-fifth year of FIC's establishment.

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Gaumard Scientific Company
Booth 309

Gaumard will display the NOELLE™ maternal and neonatal birthing system, the ZOE® gynecologic simulator and other products of interest to the global health community. Visit our booth and receive a copy of our new 2003/04 catalog.

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George Washington University Medical Center School of Public Health and Health Services
Booth 408

The George Washington School of Public Health and Health Services (SPHHS) combines public health and health services, creating, with the School of Medicine and Health Sciences, a unique comprehensive academic health center. This structure, coupled with a premier location in the heart of Washington, DC, uniquely positions the school to offer an experience unmatched by any other. Here, students can take advantage of outstanding educational research, community service and extra-curricular opportunities, rich with cultural diversity. These experiences create a solid foundation of knowledge and practice on which a successful and rewarding career in public health and health services can be built. The SPHHS comprises seven academic departments — Environmental and Occupational Health, Epidemiology and Biostatistics, Exercise Science, Health Policy, Health Services Management and Leadership, Global Public Health, and Prevention and Community Health. In addition, it has six research centers – Center of Health Services Research and Policy, Center for Global Health, Center for Risk Science and Public Health, Biostatistics Center, Biostatistics Medical Center Unit, and Center for Prevention Research – that conduct nearly $10 million in research per year.

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Global Forum for Health Research
Booth 315

Every year, more than US$70 billion is spent on health research and development by the public and private sectors. But only about ten percent of this is used for research into ninety percent of the world's health problems. This is what is called 'the 10/90 gap.' The human and economic costs of such misallocation of resources are enormous if we consider that good health is essential for economic growth and development, the fight against poverty and global security. The vision of the Global Forum for Health Research is a world in which health research is recognized as a global public good and a critical input in health system development, a world where priority is given to the study of those factors with the largest impact on people's health and to the effective delivery of research outcomes for the benefit of all, particularly the poor. The Global Forum's central objective is

to help correct the 10/90 gap in health research and focus research efforts on the health problems of the poor by bringing together key actors and creating a movement for analysis and debate on health research priorities, the allocation of resources, public-private partnerships and access of all people to the outcomes of health research. Our strategies are as follows: 1) Annual Forum meeting; 2) analytical work on the 10/90 gap and health research priorities focused on priority-setting methodologies, cross-cutting issues (such as poverty, gender, capacity strengthening, health policies), and major risk factors affecting health and diseases and conditions; and 3) communication: publications (10/90 Reports on Health Research) and website (www.globalforumhealth.org).

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Global Health Council Booths 111-113-115

The Global Health Council is the world's largest membership alliance dedicated to saving lives by improving health throughout the world. The Council informs and educates policy-makers, opinion leaders and concerned citizens in the U.S. and abroad about crucial global health issues. These efforts spur greater investment in global health and sound approaches to improving health around the world. The Council gathers, analyzes and summarizes information on international public health, disseminates this information to the global health field and provides forums for sharing for those working to improve global health. These efforts ensure that advances in the international public health field are recognized, understood and promoted – thus helping avoid needless suffering and death. Stop by our booth to explore our latest publications, become a member or just to say hello!

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Health and Child Survival Fellows Program, Johns Hopkins University Booth 310

Health and Child Survival Fellows Program (H&CSFP) prepares junior and mid-career health professionals for international careers through two-year, practice-oriented assignments with the U.S. Agency for International Development (USAID) or other similar agencies. USAID assignments can be in overseas field missions or in the U.S. All other assignments are overseas. Eligibility requirements include a master's degree in a health-related field, U.S. citizenship and a commitment to a career in international health. Candidates for specific assignments are selected from a pool of applicants. For further information, or to obtain an application for the candidate pool, visit our booth in the Exhibit Hall or the program's website or contact: Paul R. Seaton, Director by email at the address listed below.

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Helen Keller Worldwide Booth 406

Helen Keller Worldwide is among the oldest nonprofit international development organizations devoted to fighting and treating preventable blindness. The mission of Helen Keller Worldwide (HKW) is to prevent blindness, restore sight and provide rehabilitation services to blind people. We save the sight and lives of the most vulnerable people in the human family. HKW works in three regions (Africa, Asia and the Americas), encompassing twenty-five nations. Our programs are supported through two divisions: ChildSight®, which provides free vision screening and eyeglasses to needy students; and Helen Keller International, which administers programs to establish primary eye care networks, rehabilitate the irreversibly blind, and treat and prevent cataract, micronutrient deficiency, onchocerciasis and trachoma. Helen Keller Worldwide was founded in Paris in 1915 by George Kessler, who survived the sinking of the British ocean liner Lusitania. He worked closely with Helen Keller to establish training programs for Allied soldiers and sailors blinded during World War I. Later the organization established the world's leading Braille press. HKW now works in concert with the worlds of science and medicine, with governments and non-governmental organizations to help eradicate the burden of blindness.

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Hesperian Foundation Booth 203

The Hesperian Foundation is a nonprofit publisher, committed to promoting the health and self-determination of poor people around the world by making health information accessible. We produce books and other educational resources for community-based health care. Our publications, which include *Where There Is No Doctor*, *Where Women Have No Doctor*, and *Helping Health Workers Learn*, have brought essential health infor-

mation to people all over the world. *Helping Children Who Are Blind*, our latest book, is the first in our new Early Assistance Series. In the next few years, Hesperian will publish new books on environmental health and community mental health – issues that are vital to the health and well-being of poor communities, but for which few resources exist. Our other publications include *A Book for Midwives*, *Where There Is No Dentist*, and the *Women's Health Exchange* (a free quarterly newsletter). We publish English and Spanish editions of all our books.

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Institute for Reproductive Health, Georgetown University
Booth 407

The Institute for Reproductive Health at Georgetown University, funded by the U.S. Agency for International Development, conducts research and provides technical assistance to expand the range and availability of natural methods of family planning. The Institute developed and tested a new simplified method, the Standard Days Method (SDM), which helps women identify days when pregnancy is likely to occur and when it is not. The Institute is collaborating with governmental and nongovernmental organizations to introduce the SDM into reproductive health community development and family planning services in more than a dozen countries around the world. The SDM can help meet the needs of millions of couples worldwide for whom a natural method is a good option for planning their families.

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International Center for Research on Women
Booth 206

The International Center for Research on Women (ICRW) is a private, nonprofit organization, working to improve the lives of women in poverty, advance women's equality and human rights, and contribute to broader economic and social well-being. ICRW accomplishes this in partnership with others, through research, capacity building and advocacy on issues affecting women's economic, health and social status in low-and middle-income countries. ICRW has an international, multidisciplinary staff and is supported by grants, contracts and contributions from development agencies, foundations, corporations and individuals. ICRW is headquartered in Washington, DC, with an office in India. The organization was founded in 1976.

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International Medical Corps
Booth 502

International Medical Corps (IMC) is a global humanitarian nonprofit organization dedicated to saving lives and relieving suffering by providing health care training and medical relief programs worldwide. IMC is a private, nonpolitical, nonprofit, nonsectarian organization with the organizational flexibility to respond rapidly to emergency situations. IMC's mission is to improve the quality of life through health interventions and related activities that build local capacity. Since its founding, IMC has responded to more than thirty-five crises on four continents, in regions including Afghanistan, Albania, Angola, Armenia, Azerbaijan, Bosnia-Herzegovina, Burundi, Cambodia, Croatia, Democratic Republic of Congo, East Timor, Eritrea, Ethiopia, Georgia, Honduras, Indonesia, Ingushetia, Iraq, Kenya, Kosovo, Macedonia, Moldova, Mozambique, Nagorno-Karabakh, Namibia, Nicaragua, Pakistan, Rwanda, Serbia, Sierra Leone, Somalia, southern Sudan, Thailand, Uganda, Ukraine, FR Yugoslavia and Zambia. IMC provides medical training and emergency care worldwide where violent conflicts, natural disasters and other crises have left people sick, injured and without access to adequate health care. Our physicians, nurses and logisticians work in some of the world's most devastated areas to provide immediate relief and to train local health care professionals. When our teams leave, IMC trainees take over and continue providing quality care within a sustainable framework.

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International Planned Parenthood Federation, Western Hemisphere Region (IPPF/WHR)
Booth 414

IPPF/WHR's work is grounded in the belief that access to quality sexual and reproductive health information and services is a basic human right. By making these services available, IPPF/WHR helps to empower individuals to make decisions about their fertility and thus contributes to improving health and well-being, national development and environmental quality. IPPF/WHR works primarily through a network of forty-five member associations in the United States, Latin America and the Caribbean that provide ten million services each year at more than 40,000 service delivery points. Each member is a private autonomous organization, established to supply family planning and other related health services according to local needs, customs and laws. IPPF/WHR provides technical assistance and financial support to these and other reproductive health organizations, helps facilitate information sharing among

its members, and advocates for sexual and reproductive rights on a regional and international level.

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International Rescue Committee
Booth 218

The International Rescue Committee (IRC) is a nonprofit, nonsectarian, voluntary agency providing assistance to refugees around the world. The International Rescue Committee was founded at the request of Albert Einstein to assist opponents of Hitler. The IRC helps people fleeing racial, religious and ethnic persecution, as well as those uprooted by war and violence. At the outbreak of an emergency, we provide sanctuary and lifesaving assistance – rapidly delivering critical medical and public health services, shelter and food. Once a crisis stabilizes, we set up programs to enable refugees to cope with life in exile. Through training, education and income-generating programs, we help refugees acquire new skills to become self-sufficient. For those who cannot safely return to their countries and who qualify for entry into the United States, we assist in their resettlement. Our national network of regional IRC offices makes sure that new arrivals have all that they need to start rebuilding their lives.

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Intrah - The PRIME II Project
Booth 207

Intrah, an affiliate of the Medical School at the University of North Carolina at Chapel Hill, has worked over two decades to support health care providers in the poorest communities around the world. As the implementing partner of the PRIME II Project, Intrah coordinates programs to strengthen primary-level family planning and reproductive health care providers around the world. Technical leadership areas include: performance improvement, responsive training and learning, post-abortion care and consumer-driven quality.

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Ipas
Booth 211

Ipas is an international nongovernmental organization that has worked for three decades to reduce abortion-related deaths and injuries; to increase women's ability to exercise their sexual and reproductive rights; and to improve access to reproductive health services, including safe abortion care. Ipas's global and country programs include training, research, advocacy, distribution of reproductive health technologies and information dissemination.

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JHPIEGO Corporation
Booth 311

In 2003, JHPIEGO is celebrating its thirtieth anniversary by renewing its commitment to the health of women and their families by meeting the changing demands of designing and managing health services internationally. "As JHPIEGO enters its thirtieth year as a flagship international health organization, we will leverage our core strengths so that we can be responsive to our funders, our partners, but most importantly to the women and children we ultimately serve," said Leslie Mancuso, PhD, RN and JHPIEGO's CEO. JHPIEGO is building on its core strengths in HIV/AIDS, maternal and neonatal health and women's health and its affiliation with Johns Hopkins University. JHPIEGO is the only international health organization affiliated with a major health research university, enabling JHPIEGO to translate research effectively into program implementation. For example, JHPIEGO and a consortium of Johns Hopkins University affiliates are assisting CDC in implementing a worldwide initiative to reduce transmission of the HIV virus from mothers to their children. The consortium will develop model training and service delivery programs that will enable communities around the world to build and sustain their response to the AIDS epidemic. JHPIEGO is the leading maternal health international organization currently operating more than thirty programs in developing nations. JHPIEGO works through collaborative partnerships with public and private organizations as well as local communities worldwide. JHPIEGO works with international organizations including the World Health Organization, UNICEF, USAID and the Department of Health and Human Service's Centers for Disease Control and Prevention. Program implementation spans a continuum of technical assistance ranging from working at the national level with governments, ministers of health, universities, medical, nursing and midwifery schools and culminating at the local level by improving access to quality health care services.

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John Snow, Inc.
Booth 121

John Snow, Inc. (JSI) is dedicated to improving the health of individuals

and communities in the United States and around the world.

Headquartered in Boston, MA, JSI, and its affiliated organizations, including JSI Research and Training Institute, JSI do Brasil, and JSI/UK, provide high-quality technical and managerial assistance to public health programs worldwide. JSI's goal is to build local capacity to address critical health problems. JSI collaborates with local partners to assist countries, governments, communities, families and individuals to develop their own skills and identify solutions that meet their public health needs. JSI's reproductive health programs strive to enhance the health and well-being of women, their partners and families. Through management assistance, education, information and training, JSI works to improve access to and quality of health care to prevent illness and disease that impact women throughout their life span. JSI conducts research and provides technical assistance to enable agencies and health professionals to effectively and compassionately address the needs of families they serve, especially the poor and underserved. Incorporated in 1978, JSI has implemented projects in eighty-four countries. Currently, JSI operates from four U.S. and twenty-eight international offices, with more than 375 U.S.-based staff and seven-hundred host country national field-based staff.

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John Snow, Inc. – The DELIVER Project
Booth 119

DELIVER, a project sponsored by the U.S. Agency for International Development (USAID), strengthens the supply chains of health and family planning programs in developing countries to ensure the availability of critical health products for customers. In implementing DELIVER, John Snow, Inc. (JSI), the prime contractor, is building upon the accomplishments of USAID's Family Planning Logistics Management (FPLM) projects I, II and III. Administered by JSI from 1986-2000, FPLM helped establish and maintain improved logistics systems in more than thirty countries. DELIVER's motto - "No Product? No Program" - is a reminder that without a full supply of products, health programs cannot operate.

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Loma Linda University School of Public Health, Department of International Health
Booth 503

At Loma Linda University School of Public Health you'll receive a top-notch Christian education where the School's mission is to further the healing and teaching ministry of Jesus Christ to "make man whole" – body, mind, and spirit. You'll learn with others in an environment of personal attention where diversity and healthy living are embraced and promoted. You can engage in research with respected faculty. LLU School of Public Health uniquely prepares you for a career in the field as you not only learn about public health in the classroom, but also practice it in the field. The International Health and Environmental Health departments partner with the Peace Corps in offering the Master's International Program. Upon your acceptance into LLU and application to the Peace Corps, you would complete your program of study and serve two years with the Peace Corps. We offer academic credit for the field practicum, as well as a tuition scholarship for this portion. At Loma Linda University you can also earn a bachelor's, master's or doctoral degree in Environmental & Occupational Health, Epidemiology & Biostatistics, Health Administration, Health Promotion & Education, Maternal & Child Health, International Health or Public Health Nutrition. Our International Health department is represented at booth 503, so stop by to learn more about a career in public health and join others in this exciting field seeking to serve, educate and improve lives here and throughout the world.

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Mailman School of Public Health
Booth 516

The only accredited school of public health in New York City, and among the first in the nation, Columbia University's Mailman School of Public Health provides instruction and research opportunities to more than 800 graduate students in pursuit of master's and doctoral degrees. Its students and faculty engage in research and service in the city, nation and around the world, through its departments of biostatistics, environmental health sciences, epidemiology, health policy and management, population and family health, and sociomedical sciences. The school's Center for Global Health and Economic Development is a partnership of the Mailman School, The College of Physicians & Surgeons and The Earth Institute, in collaboration with other parts of Columbia University, and focuses on mobilizing global health programs to aid resource-poor countries in addressing poverty human rights issues and the burden of disease.

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Exhibitors

Management Sciences for Health
Booths 415-417

Management Sciences for Health (MSH) is a private, nonprofit organization that works collaboratively with health care policy-makers, managers, providers and consumers throughout the world using modern management techniques to strengthen health systems and improve the delivery of health services. MSH is organized around four technical centers of excellence: Health Services, Health Reform and Financing, Leadership and Management, and Pharmaceutical Management. These centers coordinate and collaborate with one another to provide multidimensional and comprehensive assistance. Our activities focus on educating health care managers, providers and consumers through technical assistance, training, publications, electronic media and conferences; applying practical management skills to public health problems in the public and private sectors; strengthening the technical, management and leadership capabilities of individuals and institutions through collaborative work and training programs; and applying and replicating innovations in health management. Since its founding in 1971, MSH has provided assistance in over one hundred countries. MSH's approximately seven hundred staff are based in our Boston headquarters, two offices in Washington, DC, and more than twenty field offices throughout the world.

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Management Sciences for Health – The EQUITY Project
Booth 419

The EQUITY Project is a seven-year (1997-2003) initiative working to address the health problems of historically disadvantaged South Africans, initially focusing on rural African women and children in the Eastern Cape Province. Established by USAID/South Africa in partnership with South Africa's Department of Health (DOH) and Management Sciences for Health (MSH), the EQUITY Project implements management interventions in collaboration with local partners. The Project works to ensure that clients at all levels—community, district, regional, provincial, and national—benefit from sustained improvements in health services. Today, the EQUITY Project works nationwide to provide innovative solutions to long-standing health challenges. Through a comprehensive approach to health management development, the DOH, with EQUITY Project technical and financial support, leads technical interventions to enhance the efficiency and effectiveness of primary health care services by improving: quality management; policy and planning strategies; health information systems, supplies, logistics, and equipment management; health financing and resource allocation; and management and leadership training.

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March of Dimes
Booth 505

The mission of the March of Dimes is to improve the health of babies by preventing birth defects and infant mortality. March of Dimes Global Programs builds on the Foundation's sixty years of experience in health education, advocacy and research support in the United States to develop and implement innovative programs that promote perinatal health worldwide. March of Dimes Global Programs uses three principal strategies in accomplishing its mission: 1) enhance professional education and research by working with partners to develop continuing education programs for health professionals, professional educational exchanges and improvements in birth defects surveillance systems; 2) expand capacity for community action through encouraging the development of parent groups in support of babies and children with birth defects; and 3) increase public awareness of the human and economic costs of birth defects by providing policy-makers and donor organizations with information to develop cost-effective solutions. By forging partnerships with public and private organizations that share our mission, the March of Dimes works to identify and promote effective, affordable and practical steps to ensure that babies in all countries are born healthy. Global Programs currently supports programs promoting rubella vaccination and national food fortification with folic acid, and is partnering with other NGOs and governments in delivering perinatal health and genetics education in Latin America, China, Ukraine and Russia, Western Europe and South Africa.

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MEASURE *DHS+*
ORC Macro
Booth 313

The MEASURE Demographic and Health Surveys (*DHS+*) project assists institutions worldwide in collecting and analyzing data for population, health and nutrition programs. This is done through long-term planning, capacity building, targeted analysis, integration and effective dissemination. *DHS+* is implemented by ORC Macro, with the Population Council and the East-West Center and is funded by USAID. MEASURE *DHS+* is a component of the MEASURE program that is designed to produce accurate and timely information on population, health and nutrition in developing countries. The ultimate objective of MEASURE is to improve policies and programs.

Daniel Vadnais, Data Dissemination Coordinator

Exhibitors

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National Library of Medicine
Booth 504

The National Library of Medicine provides FREE Internet access to its toxicology, chemical and environmental health information resources at http://tox.nlm.nih.gov. These resources include: TOXNET® (TOXicology data NETwork) databases; Haz-Map, an occupational diseases database; Tox Town, an interactive guide to commonly encountered toxic chemicals and environmental health risks; and MEDLINEplus®, a website containing consumer information on poisoning, toxicology and environmental health.

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Pan American Health Organization
Booth 404

The Pan American Health Organization (PAHO), founded in 1902, works with all the countries of the Americas to improve and raise the health and living standards of their peoples. It serves as the Regional Office of the World Health Organization, and has offices in twenty-seven countries in Latin America and the Caribbean as well as nine scientific and technical centers apart from its headquarters in Washington, DC. Last year in 2002, PAHO celebrated its Centennial, making it the oldest international public health organization in the world.

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PATH – Program for Appropriate Technology in Health
Booth 202

The Program for Appropriate Technology in Health (PATH) is an international public health organization, dedicated to improving the health and well-being of people living in the developing world and in those places with insufficient preventive health resources. PATH develops innovative technological, programmatic and cultural solutions, which are implemented through partnerships with other nongovernmental organizations, the private sector, governments and international agencies. Approximately two-thirds of PATH's financial support comes from private foundations; the remainder comes from governments, multilateral agencies and individuals.

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Pathfinder International
Booth 411

Pathfinder International provides women, men and adolescents throughout the developing world with access to quality family planning and reproductive health information and services. Pathfinder works to halt the spread of HIV/AIDS, to provide care to women suffering from the complications of unsafe abortion, and to advocate for sound reproductive health policies in the U.S. and abroad.

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Paxton International
Booth 118

Transportation solutions for over 50 years... In today's environment, program administrators rely on logistics professionals to fulfill the increasingly complex transportation components of international project management. We at Paxton International understand that in order to succeed in today's competitive market, you, the client, require a multitude of services. Limiting yourselves to standard "door-to-door" transportation services offered by traditional freight forwarders is no longer sufficient. We recognize that your time is valuable, and we are confident that Paxton can design a logistics program to meet your specific objectives. We offer your staff the opportunity to maximize control over services such as warehousing, technical inspections, international shipping, customs clearance and delivery while minimizing the amount of time and resources needed to manage and transport your general commodities and your employees' effects around the globe. Available transportation services include: warehousing; inventory control; automated barcoding; technical inspections; logistics management; transportation planning; export packaging; on-site specialized crating; project kit assembly; containerization; consolidation; container staging; marshaling; transit insurance; international carnets; oversize cargo handling; computerized cargo tracking; freight forwarding; worldwide customs clearance; delivery to remote sites; USAID program management; reporting; temperature controlled; substance packing; hazardous packing; household goods packing; corporate relocations; and records storage and disposal.

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Exhibitors

Peace Corps
Booth 416

The Peace Corps was established through the vision of President John F. Kennedy who challenged Americans to join a "grand and global alliance" to promote peace, friendship and better living conditions throughout the world. Peace Corps Volunteers help translate host country development plans into community-level action while transferring skills, promoting sustainability, and ultimately improving lives. Assignments are available in health, education, youth development, environment, agriculture, business, community development and information technology. There are opportunities in a variety of health-related fields – for both health-degreed specialists as well as those with demonstrated interest in community health. Maternal and Child Health Volunteers may travel with an immunization team to show village mothers the benefits of child immunizations while coordinating logistics and training local health workers. Nutrition Volunteers might work with local leaders and health workers to increase the knowledge of nutrition at the rural community level. HIV/AIDS Prevention Education Volunteers collaborate with local AIDS coordinators to provide education, social marketing and counseling services. And Water/Sanitation Volunteers work with communities to increase access to adequate water and sanitation services and strengthen their communities' ability to manage their own water resources. Before starting a two-year assignment, Volunteers will receive up to three months of in-country training that focuses on language, cross-cultural and technical skills. Nearly 7,000 Volunteers are currently serving in Africa, Asia, Latin America, Eastern and Central Europe, and the Pacific Islands. Special thanks to Pfizer, Inc. for their in-kind donation of exhibition space.

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People Designs
Booth 510

People Designs is a health communications firm with ten years' experience developing and producing materials that support health promotion and education activities. Our services include health communications consulting, materials planning, visual identity development, content development, design, programming and production. Materials include standard print communications (informational brochures and booklets, posters, etc.), videos, individually tailored print materials (documents tailored to the individual characteristics of each reader), and interactive Web- and CD-based programs. Our expertise includes health communications, cross-cultural and multilingual capabilities, population-appropriate design, and all aspects of development and production. The staff of People Designs has dozens of years of experience and education in health communications, design and programming. We work with public and private health promotion and health education organizations throughout the United States and the world. All of the staff at People Designs have training and experience in public health. This health focus is invaluable for a high level of quality control, which demands an understanding of what is being developed, not just how it is produced – from concept to delivery. They also have international experience developing materials, providing consultation, living and teaching in Africa, Europe, Latin America, the Middle East and Southeast Asia. We have developed materials for children and adults, lay people and health care professionals in a variety of settings – from the community to the national level. A selected listing of our clients include the World Health Organization, Ipas, USAID, Peace Corps, Harvard University, Duke University, West Virginia University, The University of North Carolina, Massachusetts Department of Public Health, New Mexico Department of Public Health, the Susan G. Komen Breast Cancer Foundation, the Centers for Disease Control and Prevention, and the National Cancer Institute.

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PharmaResearch Corporation
Booth 223

PharmaResearch is a pharmaceutical development services company that provides a wide array of pharmaceutical research activities with the goal of bringing compounds into full clinical development through new drug application (NDA) and post-marketing support. PharmaResearch is committed to improving world health and quality of life and partnering with our clients in the development of interventions for life threatening diseases. Creating committed relationships is an important part of our corporate strategy. Founded in 1995, PharmaResearch has offices in NC (Research Triangle Park and Wilmington), London, Paris, Madrid and Beijing. PharmaResearch also has enhanced capabilities through alliances and partnerships throughout Western and Eastern Europe, Australia, South Africa and Latin America. Organized to mimic the structure of pharmaceutical companies with synergistic therapeutic units, PharmaResearch has carefully selected management staff with extensive backgrounds in both pharmaceutical and contract research organizations who bring with them the therapeutic and scientific expertise and experience needed for successful drug development. Additionally, our staff has a comprehensive knowledge of IND, NDA, and sNDA processes and in-depth knowledge of the regulatory and clinical environments within Europe. These professionals provide a foundation of scientific expertise that enables PharmaResearch to provide both consultative and product development services. PharmaResearch has an excellent track record for teamwork across its multidisciplinary teams. PharmaResearch has been successful in achieving aggres-

sive timelines across a variety of programs as well as establishing innovated post-marketing support programs. The company has developed a strong reputation with its clients and can boast that ninety-five percent of its contracts are from repeat business.

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busdev@pharmaresearch.com
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Population Action International
Booth 303

Population Action International (PAI) is an independent policy group working to make clear the linkages between population, reproductive health, the environment and development. Through research and advocacy, PAI seeks to strengthen public awareness and political and financial support worldwide for population programs grounded in individual rights. At the heart of PAI's mission is its commitment to universal access to family planning and related health services, and to educational and economic opportunities, especially for girls and women. Founded in 1965, PAI accepts no government funds.

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Population Council
Booth 201

The Population Council's founding principles are to improve the well-being and reproductive health of current and future generations around the world and to help achieve a humane, equitable and sustainable balance between people and resources. An international, nonprofit, nongovernmental organization, the Council conducts biomedical, public health and social science research on global issues including reproductive health, HIV/AIDS and population trends, and helps build research capacities in developing countries. The Council, headquartered in New York and governed by an international board of trustees, employs nearly six hundred people with expertise in a wide array of scientific disciplines. It has eighteen offices in Africa, Asia, and Latin America and works in more than seventy countries.

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Population Leadership Program
Booth 318

Since 1994, the Population Leadership Program (PLP), a project of the Public Health Institute, has evolved into a program focused on building leadership skills in the U.S. Agency for International Development (USAID) Bureau of Global Health. During that time, PLP has successfully placed more than ninety senior-level leadership fellows with USAID-funded health programs throughout the developing world. PLP works in three key result areas: recruitment and placement of fellows, professional development and support, and organizational consulting. PLP recruits and places senior-level fellows who are committed to increasing technical capacity in the global health sector and bring fresh ideas and an extraordinary depth and breadth of experience to their assignments in USAID-funded programs. The PLP e-list, http://listserv.popldr.org, announces new positions via the Internet as soon as they become available. Professional development and support enhance the leadership, management and technical capabilities of PLP fellows and participating USAID staff in order to improve performance of select global health programs. PLP hosts an annual leadership retreat at USAID that has scored consistently high ratings. Organizational consulting offers USAID a wealth of experience and innovative ideas to help manage change and improve work processes within the global health sector. PLP has a dozen seasoned organizational consultants available to USAID Washington and the Missions to assist in reorganization, teambuilding and problem solving.

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Email: recruitment@popldr.org
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Population Reference Bureau
Booth 515

Founded in 1929, the Population Reference Bureau (PRB) is the leader in providing timely and objective information on U.S. and international population trends and their implications. PRB informs policymakers, educators, the media and concerned citizens working in the public interest around the world through a broad range of activities, including publications, information services, seminars and workshops, and technical support. Our efforts are supported by government contracts, foundation grants, individual and corporate contributions, and the sale of publications. PRB is governed by a Board of Trustees representing diverse community and professional interests.

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Population Services International
Booth 301

A nonprofit group based in Washington, DC, Population Services International (PSI) is the leading social marketing organiza-

tion in the world, with projects in seventy countries on five continents. PSI uses social marketing to deliver health products, services and information that enable low-income and other vulnerable people to lead healthier lives. We make these products and services accessible and affordable by harnessing private sector resources, including creative application of cost-effective marketing and communications resources and techniques.

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Project HOPE
Booth 104

Project HOPE is a nonprofit health education organization founded in 1958 and identifiable to many by the SS HOPE, the world's first peacetime hospital ship. Project HOPE now conducts land-based medical training and health education programs in thirty-three countries in Africa, Central and South America, the Middle East, Asia and Eastern Europe. Project HOPE works to achieve sustainable improvements in health by focusing its efforts in five major areas: infectious diseases (especially Tuberculosis and HIV/AIDS); maternal and child health (including the village health bank program); health professional education; health facilities development and training; and humanitarian assistance. Our work with local health professionals and community healthcare providers in-country ensures the sustainability of our programs around the world and enables us to achieve our goal of "helping people to help themselves." Project HOPE works in close partnership with Ministries of Health as well as local and international partners to achieve its mission of providing "Health Opportunities for People Everywhere."

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Email: recruit@projecthope.org
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Public Health Jobs Worldwide
Booth 216

Public Health Jobs Worldwide is a news service for individuals seeking positions in the field of public health. Our bi-weekly publication describes current job openings with health programs based in the U.S. and overseas. Each issue lists over three hundred job openings and reaches approximately 15,000 readers.

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Email: keeby@mindspring.com
Website: www.jobspublichealth.com

Reproductive Health for Refugees Consortium
Booth 217

The Reproductive Health for Refugees Consortium (RHRC) was founded in 1995 to increase access to a broad range of quality, voluntary reproductive health services for refugees and internally displaced persons around the world. The seven members include: American Refugee Committee; CARE; Columbia University Mailman School of Public Health, Heilbrunn Department for Population and Family Health; International Rescue Committee; JSI Research and Training Institute; Marie Stopes International; and the Women's Commission for Refugee Women and Children. RHRC members are currently active in seventy sites in thirty countries. The RHRC pooled their expertise to create a united front in the battle to win commitment and funding for reproductive health programs for displaced populations globally. The RHRC works in four essential and complementary technical areas of reproductive health: family planning; sexually transmitted infections, including HIV/AIDS; safe motherhood, including emergency obstetrics; and gender-based violence. The RHRC also focuses on the adolescent population. RHRC agencies are active members of the Interagency Working Group (IAWG) on refugee reproductive health, which has significant influence on humanitarian policy. RHRC activities support the following objectives: improve reproductive health service delivery; improve design, monitoring and evaluation of reproductive health activities; provide training in reproductive health issues to program planners and service providers; contribute to the growing body of research on reproductive health for refugees; provide opportunities to other agencies to develop reproductive health capabilities via the small grants program; advocate for reproductive health for refugees; and document and disseminate information to the larger international community.

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RHINO: The Routine Health Information Network
Booth 123

The Routine Health Information Network (RHINO) strengthens the role of evidence-based decision-making by engaging organizations and professionals in promotion of effective collection and use of routine health information in developing countries. RHINO services and products include: the *Potomac Statement on Investment in Routine Health Information in Developing Countries*, a publication that discusses the benefits of routine health information and proposes steps to increase and guide investment in this area; RHINO Website, which contains recent RHINO publications and information on our upcoming workshop on Enhancing Quality and Use of

Exhibitors

Information at the District Level; RHINO-List, a listserv for health information professionals and users to promote communication among those interested in routine health information collection and use throughout the world; the RHINO On-Line Forum, a periodic electronic discussion moderated by a health information professional with expertise in specific topics of interest; and an annotated on-line bibliography of articles related to routine health information system development. Future activities include: The RHINO Register, a database of health information professionals; a Workshop in the Eastern Cape of South Africa on "Enhancing Quality and Use of Information at the District Level"; and continued research and advocacy on routine health information systems. RHINO is financially supported by USAID through the MEASURE Evaluation Project, and through contributions from partner organizations.

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Website: www.cpc.unc.edu/measure/rhino/rhino.html

Save the Children Federation
Booth 220

Save the Children (SC) works to make lasting, positive changes in the lives of children in need. Our health programs build on experience gained from extensive, field-based operational programs with special emphasis on child and newborn survival, reproductive health, HIV/AIDS, and school health and nutrition. We are partners in the USAID-supported BASICS II, PRIME II, JHU Health Communications Partnership (HCP), and NGO Networks for Health Projects, and work in partnership with PVOs, local NGOs and government counterparts to build capacity and improve health programs that address the critical health needs of marginalized and under-served populations in developing countries. Through our field-based programs, SC seeks to inform policies and programs in the countries where we work by documenting new or innovative approaches to improving health practices and services at the community level. With the support of the Bill & Melinda Gates Foundation, Save the Children also leads the global Saving Newborn Lives Initiative to advance policies and programs and mobilize resources needed to improve neonatal health and survival.

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Social & Scientific Systems, Inc.
Booth 110

Social & Scientific Systems, Inc. (SSS) serves public and private sector clients by providing technical assistance and training in support of public health programs worldwide, including program design and evaluation, statistical programming, data analysis, clinical trials support, meeting and conference planning, graphic design and information technology support. Founded in 1978, SSS has approximately 350 employees and revenues of more than $70 million. The SSS Biomedical Research Support division supports three major HIV/AIDS clinical trials networks funded by the National Institutes of Health. The Computer Systems and Data Analysis division supports public health researchers and policy-makers at the federal and state levels through statistical programming, data analysis, database development and maintenance, survey support, microsimulation modeling, system design and development, and Internet database applications. In 2002, SSS acquired TvT Associates, a consulting firm with a twenty-year history of providing technical assistance and advisory services in international health. Now fully integrated into Social & Scientific Systems as the TvT Global Health and Development Strategies division, the group continues to expand on its experience in program planning, design and evaluation in the areas of HIV/AIDS, maternal and child health, infectious diseases, family planning and reproductive health. Current health projects with the U.S. Agency for International Development include the Synergy Project, which helps USAID Missions and Bureaus design, document and learn from international HIV/AIDS programs implemented by USAID cooperating agencies and other partners.

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University of Alabama at Birmingham Sparkman Center for International Public Health Education
Booth 320

The John J. Sparkman Center for International Public Health Education at the University of Alabama at Birmingham (UAB) was established in 1979 with a congressional appropriation through the U.S. Agency for International Development (USAID). The vision behind establishment of the Center recognized the global nature of health problems, the impact of health on human development, and the need for international collaboration in resolving major health issues. The Center collaborates with institutions and government agencies in developing countries as well as with other international organizations in a variety of public health education, research and training activities. A successful history of collaboration with partners includes work in Asia, Africa, the Caribbean, Latin America and Eastern Europe. Although located in the School of Public Health, the expertise of over seventy faculty scholars across UAB are drawn upon for planning and implementing programs and activities, such as evaluating public health curricula; organizing and teaching public health semi-

nars, workshops, courses and degree programs; publishing and disseminating information useful to the international health community; implementing training and research; and organizing and sponsoring conferences and symposia on international public health topics.

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University of Michigan - Population Fellows Program Booths 317-319

The Population Fellows Programs were designed to develop future leaders in the field of international population. To do this, we provide fellowships and related activities that achieve three complementary goals: offer career-development opportunities to promising professionals; provide technical assistance to organizations working on population-related issues in the developing world; and advance the field by supporting best practices, intersectoral cooperation and diversity among practitioners. The Programs now include seven components designed to further the professional development of those building careers in international family planning and reproductive health; exploring the emerging field of population-environment; or engaged in essential dialogue on the relationships among population dynamics, environmental degradation and international security. Our Population and Population-Environment Fellowships involve placing early-career U.S. professionals on two-year assignments with organizations addressing family planning, reproductive health and population-environment in developing countries. Internships and related preparatory experiences are also available, as are fellowships for early-career professionals from Latin America and sub-Saharan Africa that aim to build developing-country capacity to offer leadership in international population.

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University Research Co., LLC – The Quality Assurance Project Booth 508

University Research Co., LLC (URC) specializes in quality management, communication, research and training applied to strengthening health and population programs in developing and middle-income countries and in the United States. Since 1965, URC has helped government and private sector clients design, implement and evaluate programs that address health, social and educational needs. URC's core practice areas are Communications & Outreach, Education & Training, Health & Population, Quality Management, and Research & Evaluation. URC has worked for USAID and other international development agencies since 1981, managing global, regional and country technical assistance programs in over fifty countries. We specialize in developing client-oriented delivery systems to enhance the quality, efficiency and impact of health care services. Through field-based projects and technical assistance, URC helps effect organizational change to bring improved services to people in need. URC's Quality Assurance Project (QAP) provides technical assistance in the management of quality assurance and workforce improvement in health care, helping develop feasible, affordable approaches to comprehensive change in health service delivery. Other major URC international projects include the Calidad en Salud project in Guatemala, the Benin Integrated Family Health Program (PROSAF) and the Cambodia Health Systems Strengthening Project. URC also serves as a major subcontractor on the Partners for Health Reform Project (PHRplus) and the Maram Project in the West Bank and Gaza, and provides technical support to the Bangladesh NGO Service Delivery Program.

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Website: www.qaproject.org
OR www.urc-chs.com

U.S. Agency for International Development Booth 102

The U.S. Agency for International Development's programs in global health represent the commitment of the U.S. government to expand access to family planning, enhance maternal and child health, contain the spread of infectious diseases, and prevent the transmission of HIV/AIDS and other sexually transmitted infections.

Marcia MacNeil
U.S. Agency for International Development
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Website: www.phnip.com

U.S. Department of Health and Human Services – Office of Global Health Affairs Booths 106-108

The U.S. Department of Health and Human Services (HHS) is responsible for protecting and promoting the health of the people of the United States. Through its agencies, HHS cooperates with more than seventy-five countries globally; works closely with agencies of the United Nations system, most prominently the World Health Organization, UNICEF, the World Bank, the UN High Commissioner for Refugees, and the UN Economic and Social Council; works with other multilateral partners such as the Organization for Economic Cooperation and Development, the Group of Eight, and the Asia Pacific Economic Cooperation; and assists in the implementation of health aspects of the U.S. Foreign Assistance Program as a partner with the Department of State and the U.S. Agency for International Development.

Mary Lou J. Resko
Department of Health and Human Services/OS/OGHA
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Exhibitors

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Website: www.globalhealth.gov

US Pharmacopeia (USP) Booth 208

US Pharmacopeia (USP) was awarded a five-year cooperative agreement by USAID's Center for Population, Health and Nutrition to implement the USP Drug Quality and Information Program. The program helps to ensure the quality of pharmaceuticals and their informed and appropriate use around the world. Based on its expertise, USP focuses on four areas in this program: ensuring drug product quality through uniform methods of testing and analysis; continuing education for physicians and pharmacists; development and dissemination of evidence-based drug and therapeutic information; and partnerships with other key organizations supporting PHN strategic objectives. USP is a nongovernmental organization that promotes the public health by establishing written standards and reference materials to ensure the quality of medicines, dietary supplements and other health care products. These standards are developed by a unique process of public involvement and are recognized worldwide. In addition, USP promotes health care through its Dietary Supplement Verification Program, pharmacopeial education programs and patient safety solutions. USP is a 501(c)(3) not-for-profit organization that achieves its goals through the contributions of volunteers representing pharmacy, medicine and other health care professions, as well as science, academia, government, the pharmaceutical industry and consumer organizations. Join us on Tuesday, May 28 at 5:30 PM in the Exhibition Hall to attend a poster presentation by USP Drug Information Specialist Daniel Seyoum on "Ceftazidime and Imipenem for the Treatment of Melioidosis;" and visit our booth to learn more about USP's global initiatives to promote the public health.

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Email: uspdqi@usp.org
Website: www.usp.org

World Vision Booth 405

Founded in 1950, World Vision is an international Christian humanitarian organization serving the world's poorest children and families in nearly one hundred countries. World Vision's assistance extends to all people, regardless of religious beliefs, gender, race or ethnic background. Driven by faith, World Vision is your partner in enabling the world's children to realize their God-given potential by tackling the root causes of poverty. We are looking for spiritually mature professionals in health, agriculture, food aid and food security, micro-enterprise development, finance, communications, peace building and civil society initiatives, and relief. Applicants need at least two years' previous experience working and living in a developing country.
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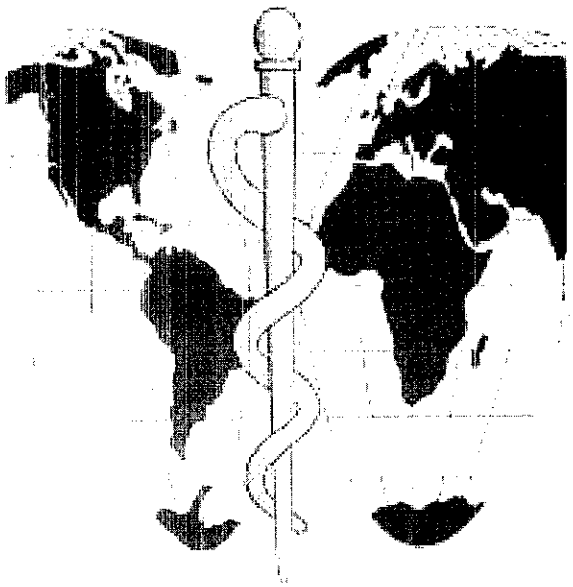

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The Population Fellows Program places early-career professionals on two-year assignments with international agencies, government institutions, and NGOs working to improve family planning and reproductive health programs in the developing world.

The Population-Environment Fellows Program places early-career professionals on two-year assignments with projects that combine assistance for threatened environments with attention to the population dynamics and reproductive health needs of the communities living within them. *Applicants must have expertise in both population and environment.*

Graduate Applied Project (GAP) Mini-Grants are available to first-year graduate students who need supplemental funding for internships in international family planning or population-environment.

The Summer Certificate Course in international population, family planning, and reproductive health provides an intensive two-week introduction to the field's fundamental principles and practices.

The Professional Exchange for Applied Knowledge (PEAK) Initiative aims to build the capacity of professionals and organizations from developing countries to offer leadership in the fields of family planning, reproductive health, and population-environment. Funded by the Compton and Hewlett Foundations, this initiative features a two- to six-month fellowship for early-career professionals from Latin America and sub-Saharan Africa, along with a variety of organizational development activities.

The Programs offer other resources including a job-postings listserve and Minority-Serving Institutions Initiative.

For more information, please visit booth 317/319
or attend our joint reception with the Population Leadership Program
on May 28, 2003, 6:30-8:30 p.m. at the Omni Shoreham Hotel, Congressional Room A.

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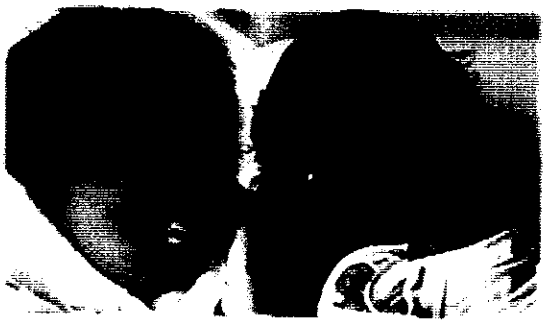
The Population Fellows Programs are funded by USAID and administered by the University of Michigan • EOE
Applicants for fellowships (except PEAK) and GAP Mini-Grants must be U.S. citizens or permanent residents

CARE Ryan White ACT

The HIV/AIDS Bureau (HAB), one of the four bureaus in the Health Resources and Services Administration (HRSA), administers the treatment and Ryan White CARE Act which provides medical support services for low-income, underinsured or uninsured individuals and families affected by HIV/AIDS. Each year the CARE Act provides HIV/AIDS care to more than 500,000 people nationwide – two-thirds of whom are from racial and ethnic minorities.

HIV/AIDS Bureau • 5600 Fishers Lane • Rm. 11A-33
Rockville, MD 20857 • 301-443-6652 • 301-443-0791 (fax)
http://hab.hrsa.gov

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration
HIV/AIDS BUREAU



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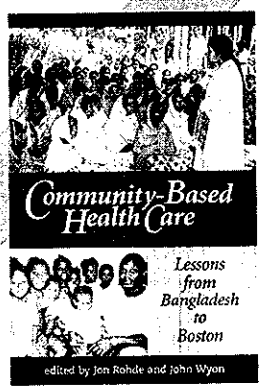

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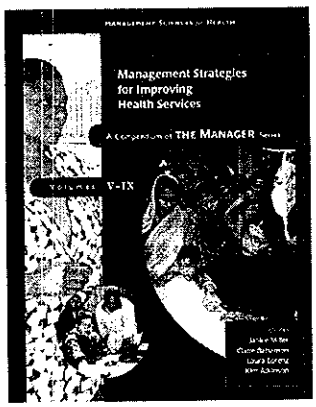

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NAME: Khadijat Mojidi

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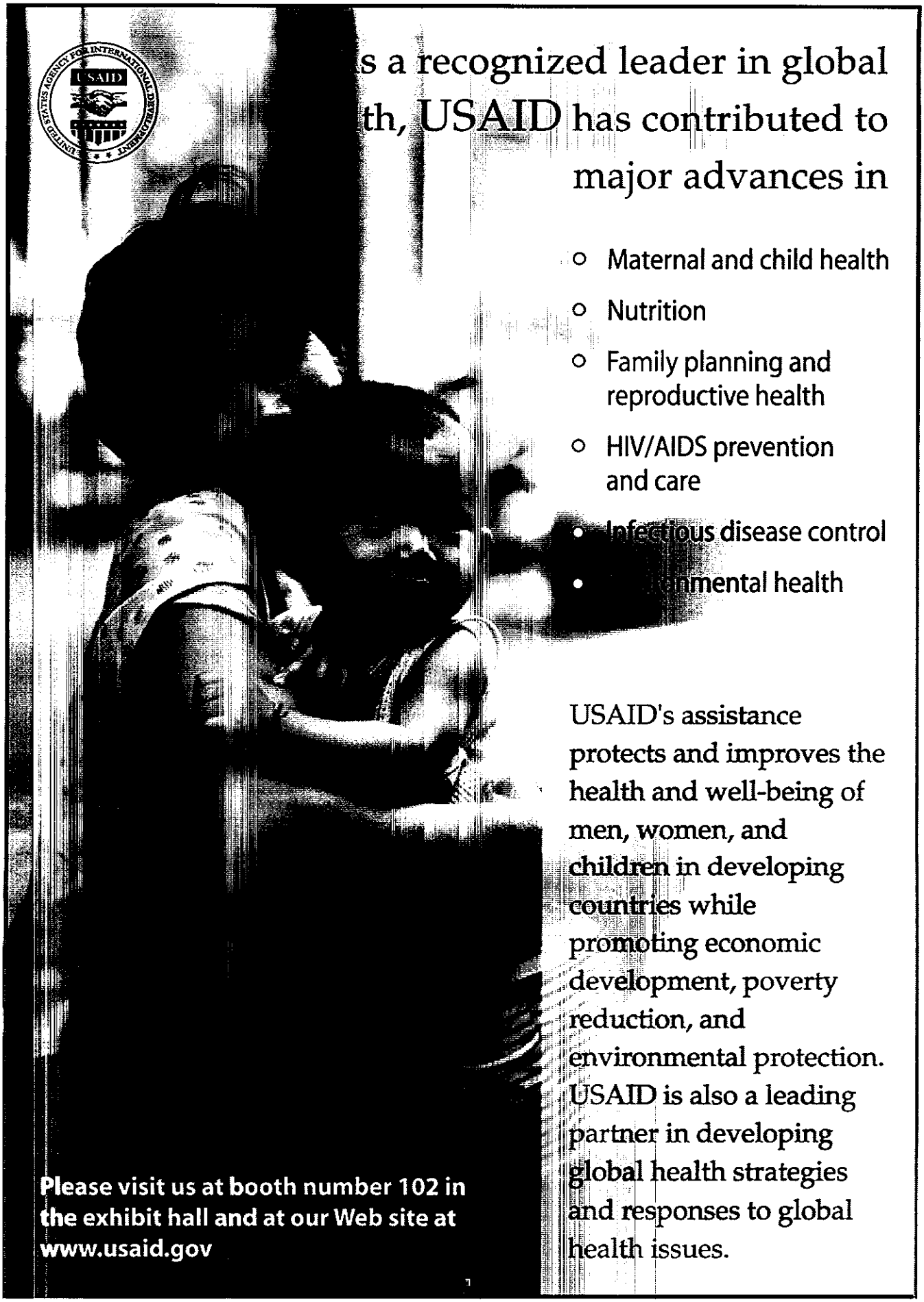
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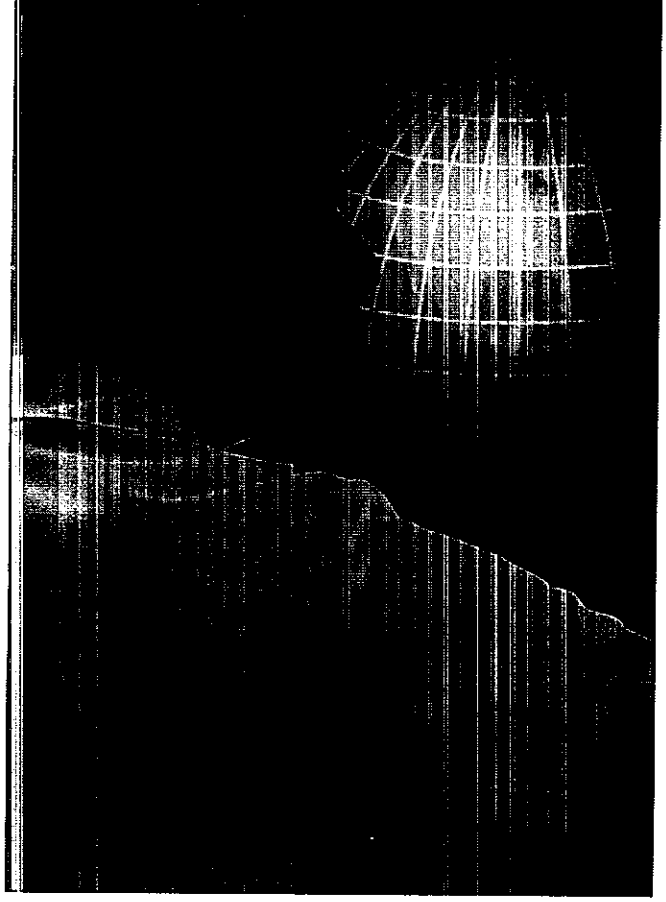

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For more information, contact Jessica Rowe at jpomer@jhpiego.net.

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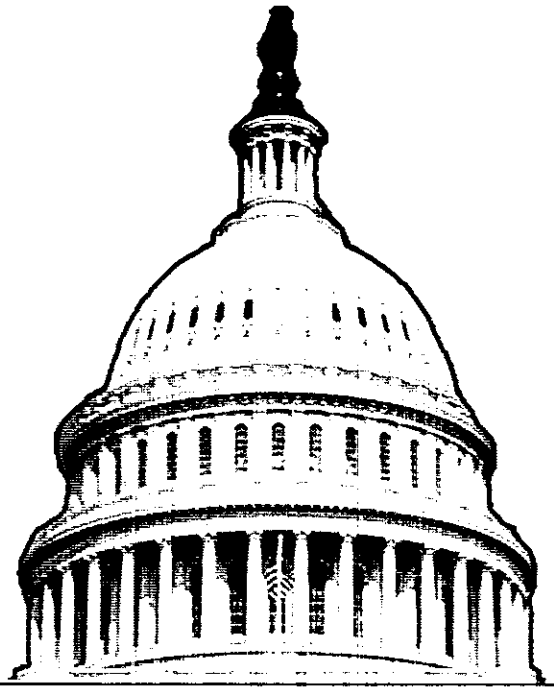

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Abstracts

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A1
People Power: Strategies for Improvement among Health-Care Workers

Improving Quality of Sexually Transmitted Infections Services within Peri-urban Communities

LAHOUCINE HASSINE

LEARNING OBJECTIVES: Participants will be able to indicate two factors that generate dynamics of change in a local health team to better respond to the health needs of the peri-urban population.

BACKGROUND: Taroudant province in Morocco is known for its agricultural production and export and seasonal workers of both genders. Over the years, many of these workers have settled in the province and become a peri-urban marginalized community. Sexually transmitted infections (STIs) and diseases over the past five years have become a serious epidemiological issue, with 4,056 new cases screened or 25 percent of the female workers.

METHODOLOGY AND RESULTS: With the assistance of a regional technical working group, four health centers in the region initiated a change process to improve quality of STI screening and treatment. During this one-year project, the screening, diagnosis and treatment rate of individuals with STIs who were visiting health centers for other reasons became universal. The major improvement was to provide respect of patient privacy through changing to a one-way patient flow in the health center. This change was the result of teamwork by the health center staff. Another improvement was complete adherence by health center staff to the national syndromic approach standards for STI treatment.

CONCLUSIONS: Introducing a dynamic of change allowed improvement of quality of screening and treatment of STIs in a growing, marginalized peri-urban environment. The local health team received continuous assistance from the regional technical group. Consequently, the project health centers are now 100 percent successful in screening, diagnosis and treatment of STIs in patients using other services.

PARTNERS: USAID, John Snow, Inc.

ADDITIONAL AUTHOR: Dr. Tibary

A1
People Power: Strategies for Improvement among Health-Care Workers

Strategies to Improve Case Detection, Case Holding and Cure Rates among Tuberculosis Patients in South Africa

TINA MAARTENS

LEARNING OBJECTIVES: Participants will gain an understanding of interventions that significantly increase tuberculosis (TB) case finding, case holding and cure rates.

BACKGROUND: TB case management in South Africa is based on the DOTS (directly observed treatment therapy, short course) strategy and is supported by an extensive program for training providers. However, program records reveal unsatisfactory levels of smear conversion and case detection. A rapid assessment of the quality of care in the program identified a number of specific opportunities to improve the adherence of providers to treatment guidelines, screening of suspect cases, record keeping, follow up of patients, and patient compliance with the DOTS regimen. In ten sub-districts, the staff of facilities where TB is managed received training in modern quality assurance methodologies. At each facility, multidisciplinary teams were created to analyze problem areas and test interventions to improve quality. No additional resources were provided for quality improvement. To encourage providers to follow treatment guidelines more closely, the teams focused on systematically communicating the guidelines and their rationale, expanding monitoring and performance feedback by supervisors, and providing necessary training. Teams also reorganized record keeping, including follow up of patients, and provider incentives for following the guidelines were implemented. The community element of DOTS was addressed by introducing mapping of patients' homes for client tracking and by more formal management of community volunteers. Over the last six months, significant improvements in case finding, case holding and cure rates have been observed in most participating health facilities, with minimal cost. For example, many clinics have seen improvements of 15 percent or more in case finding. Also, improvements in adherence to the DOTS drug protocol are evidenced by a 10-20 percent increase in negative sputum samples at the end of the intensive treatment phase. The quality improvement teams plan to continue to monitor measures of performance and to pursue additional improvements based on quality assurance methodologies.

CONCLUSIONS: Previously, quality improvement methodologies had only limited application in TB programs. However, these results suggest that such approaches could provide an important complement to both traditional assistance strategies and innovative strategies that address TB, sexually transmitted infections and HIV simultaneously.

PARTNERS: Department of Health, the Quality Assurance Project.

ADDITIONAL AUTHORS: Maria Fakude, Neeraj Kak

A1
People Power: Strategies for Improvement among Health-Care Workers

Using Evidence to Improve Quality along the Thailand-Burma Border

SOPHIA

LEARNING OBJECTIVES: Participants will be able to identify ways to use monitoring and evaluation techniques in an unregistered clinic with health workers who lack legal status and formal clinical training. Participants will also learn how to use monitoring and evaluation results to identify and prioritize program interventions in such an environment.

BACKGROUND: The Mae Tao clinic is an unregistered clinic located in Mae Sot, Thailand, along the Thailand-Burma border. Established in 1989, it provides services for illegal migrant workers in Thailand and internally displaced people (IDP) from Burma. In 2001, the clinic initiated a monitoring and evaluation project to improve the quality of reproductive health (RH) services. A baseline assessment was conducted using a facility audit, observation checklists and a client exit interview. Using evidence from the assessment, the RH team initiated a number of interventions. First, the RH team purchased basic delivery and emergency obstetric care equipment to improve the facility infrastructure. Audiovisual equipment was also acquired to broadcast behavior change communication messages to improve client knowledge, attitudes and behaviors. Second, outside organizations conducted training activities to strengthen staff capacity in weak areas identified through the assessment. The International Planned Parenthood Federation affiliate in Thailand (Planned Parenthood Association of Thailand) conducted training on stock and inventory management. EngenderHealth conducted training on post-abortion care (including family planning counseling) and infection prevention. This training also introduced COPE (client-oriented, provider-efficient), a methodology used for quality improvement. Likhaan, Inc. conducted an adolescent health training of trainers to improve staff ability to effectively work with this important target group. Third, the team, with the assistance of several technical consultants, reviewed and revised patient charts, registries and other medical records. The new records will assist health workers to administer complete health examinations (including counseling) and will also ensure consistent data collection. Finally, the team (with technical assistance) developed job descriptions and an organizational chart to clarify staff roles and expectations.

CONCLUSIONS: Monitoring and evaluation results can successfully be used in nontraditional health settings to identify areas of strength and weakness, and to initiate interventions to improve the quality of services.

PARTNERS: Local ethnic groups, NGOs, Thai Public Health

ADDITIONAL AUTHORS: Tara M. Sullivan, Cynthia Maung

A2
Knowing to Caring: VCT, MTCT and Home-Based Care

Preventing Mother-to-Child Transmission of HIV in Zambia

MELISSA BARRETT

LEARNING OBJECTIVES: Participants will be able to: 1) list the essential components of a successful prevention of mother-to-child transmission (PMTCT) program; 2) identify indicators for measurement of infant feeding and PMTCT; and 3) describe the results of an integrated PMTCT program in Zambia.

BACKGROUND: In 1999, LINKAGES received funding from USAID/Zambia to develop the Ndola Demonstration Project (NDP) as a model PMTCT program. The NDP was implemented from 2000 to 2002 in six government mother and child health (MCH) clinics and the seven communities they serve on the outskirts of Ndola City in northern Zambia. The program introduced counseling on HIV and infant feeding for women seeking prenatal services at intervention clinics; offered free HIV testing as part of routine prenatal care in the existing health facilities and enhanced existing community services for greater follow-up and support of all women. Single-dose nevirapine (NVP) prophylaxis was added to the package of services in June 2002. By 2002, the program had expanded within Ndola district and to three additional districts in different regions of the country.

METHODOLOGY AND RESULTS: The primary indicators used for measuring program success are the mixed feeding, exclusive breastfeeding and voluntary counseling and testing (VCT) rates for all antenatal women. Infant feeding indicators come from community-based, random household baseline and endline surveys. VCT data come from service data collected at intervention clinics as well as from the household surveys. Key findings from random household surveys of women during the demonstration project showed a decrease in the mixed feeding rate of infants less than six months old, from 42 percent at baseline to 30 percent at endline. Surveys also showed an increase in the exclusive breastfeeding rate of infants, from 57 percent to 70 percent. VCT uptake had also increased but remained low, with 5 percent of women reporting having tested at baseline and 13 percent at endline. An aggressive strategy for increasing uptake of VCT was introduced in all program sites in 2003. Service statistic data show a corresponding upward trend in the percentage of antenatal clients choosing to test, from 13 percent in 2002 to 31 percent for January-February 2003. Preliminary service data on NVP compliance, from June 2002 to February 2003, show 68 percent of women who receive NVP consume the dose; of those women who report consumption of NVP, 91 percent of their infants also receive their dose.

CONCLUSIONS: Integrating PMTCT services into existing clinic and community MCH services has led to increasing levels of optimal infant feeding and a reduction in mixed-infant feeding. It is possible to increase the exclusive breastfeeding rate even in areas of high HIV prevalence where women are made increasingly knowledgeable about the risk of MTCT of HIV. Stigma associated with HIV still affects VCT uptake, although recent service data show that approaches in the expansion sites have been successful in getting more women to test for HIV.

PARTNERS: District Health Management Teams, Central Board of Health, National Food and Nutrition Commission, National AIDS Control Program, Hope Humana, Horizons Program, Zambia Integrated Health Project, CDC, Advance Alliance, Center for Infectious Disease Research in Zambia

ADDITIONAL AUTHORS: Earnest Muyunda, Jean Baker, Carolyn Kruger, Nadra Franklin

A2
Knowing to Caring: VCT, MTCT and Home-Based Care

Voluntary Counseling and Testing Services for High-Risk Populations in Togo: Military and Youth

AUGUSTE KPOGNON

LEARNING OBJECTIVES: Participants attending this session will learn pitfalls and best practices for designing and operating voluntary counseling and testing (VCT) services which target two groups at high risk for HIV/AIDS: youth and military personnel.

BACKGROUND: HIV in Togo is a generalized epidemic, with a 6-8 percent prevalence in the general population and a 2-3 percent higher prevalence in certain high-risk groups. VCT for HIV is a proven prevention tool, both for those who are sero-positive as well as those who are sero-negative. Because VCT services are not yet widely available in Togo and are relatively expensive to operate, the most effective initial strategy is to target high-risk sub-populations, such as youth (aged 16-24 years) and members of the military. Population Services International (PSI)/Togo has two HIV/AIDS programs targeting youth ('100% Youth') and the military ('Operation Full Protection'). Both programs consist of peer education networks, improved access to prevention methods, and improved access to clinical and testing services. There are currently nine STI (sexually transmitted infection) clinics serving the two programs. VCT services are offered at four of these clinics, two for each program. Promotion of VCT services is a challenge, particularly when there is little to offer those who test positive for HIV. PSI/Togo uses peer educators in both these high-risk populations to promote the benefits of knowing one's HIV status; these peer educators refer their friends and colleagues for testing and counseling. PSI/Togo has also designed media materials promoting VCT to these two groups, emphasizing that those who test negative can work to remain negative, and those who test positive can avoid infecting others and re-infection, and can take steps to protect their health.

CONCLUSIONS: Designing testing and counseling services for high-risk groups is a challenge, as messages and methods of communication need to be tailored to each group. Working with the military is especially sensitive and is facilitated by having a military liaison officer coordinating with the VCT project. Peer educators provide an entry into both these communities and help to convince people of the value of learning one's HIV status. Integrating VCT into existing clinics targeting these groups reduces stigmatization and costs. PSI is working to replicate both youth and military VCT programs in several countries in Africa. The 'integration' model of VCT makes it less expensive and more flexible for adaptation.

PARTNERS: ATBEF, SNSJA, Arc-en-ciel, FTACU, Aja for Youth, Togolese Armed Forces, United States Department of Defense

ADDITIONAL AUTHOR: Chastain Fitzgerald

A2
Knowing to Caring: VCT, MTCT and Home-Based Care

Monitoring HIV/AIDS Home-Based Care in South Africa

JEAN-PIERRE SALLET

LEARNING OBJECTIVES: Participants attending this session will learn how to establish a monitoring system for the delivery of home-based care to HIV/AIDS patients.

BACKGROUND: In South Africa, over 40 percent of the causes of death are attributed to HIV/AIDS. The government is working with all sectors to address this critical situation. In 2000, government and private partners established the Bambisanani Project to assist three communities of the former Transkei homeland to respond to the emerging HIV/AIDS-related needs for care and support. One of the project strategies has been to mobilize the community to support the delivery of home-based care to HIV/AIDS patients, children in distress and patients receiving tuberculosis directly observed treatment therapy, short-course (DOTS) through trained caregivers. A simple database program was developed to monitor the delivery of these services. The system has evolved into a comprehensive tool that tracks the number of visits, their length, the activities conducted, the supplies used and the evolution of the patient's status. Caregivers record data on each visit and these are captured in the database by project staff. In its first three months, the database has included records of over 1,767 visits by 140 caregivers to 595 patients. The program can be used to calculate the direct and indirect costs associated with these services and to assess the various income-generating activities. Performance indicators are used to monitor the value added of community participation and to assist in prioritizing areas of intervention and identifying areas that need strengthening.

CONCLUSIONS: The use of performance indicators provides an objective measure of the effectiveness of any intervention. In the Bambisanani Project, these indicators help identify the impact of home-based care on HIV/AIDS patients, assess the cost of services and identify weaknesses in the current programs. The database program allows the program staff to review their strategies and increase the impact of their interventions, both of which are key components of effective programs in resource-constrained environments.

PARTNERS: The Bambisanani Project, USAID, Management Sciences for Health/EQUITY Project, the Eastern Cape Provincial Department of Health

ADDITIONAL AUTHORS: Siziwe Qolohle, Litha Klaas

A3
It's Back: The Return of Vector Control as a Tool Against Malaria

Integrated and Sustainable Malaria Control in Zambia's Copperbelt

JUERG UTZINGER

LEARNING OBJECTIVES: Participants will be able to summarize the key features of integrated and sustainable malaria control programs that were implemented more than 50 years ago, and draw conclusions for contemporary malaria control.

BACKGROUND: Malaria claims more than 1 million lives every year, causes an estimated 300-500 million clinical attacks annually, and brings about social and economic hardship both at the household and at the macroeconomic level. The problem is most severe in sub-Saharan Africa, where 85 percent of the current malaria burden is concentrated. There are several control tools with proven efficacy and cost-effectiveness, i.e., insecticide-treated bed nets and indoor residual spraying, and efforts are underway to scale up these interventions. Notable missing elements are discussion of the potential of environmental management, particularly those interventions targeted at the larval stages of the malaria vectors, and integrated control approaches, implementing multiple interventions simultaneously.

METHODOLOGY AND RESULTS: We reviewed the literature and identified multiple integrated malaria control programs. Prominent among them are programs launched in the late 1920s and implemented and sustained for 20 years at mining communities in the Zambian copperbelt. Key programmatic features were: 1) strong emphasis on environmental management, consisting of vegetation clearance, modification of river boundaries, draining swamps, oil application to open-water bodies and mosquito-proofing houses; 2) implementation of these malaria control measures in concert with case management and utilization of bed nets; and 3) tuning the packages of interventions to the local ecological and epidemiological settings to sequentially achieve the desired outcomes. We demonstrate that these programs were highly successful in averting deaths, malaria attacks, disability adjusted life years and work shift losses. Over the 20-year period of intervention, we estimate that integrated malaria control averted more than 14,000 deaths, 500,000 malaria attacks and almost 1 million work shift losses, at a total cost of approximately US$ 11 million. These expenditures were negligible when compared to copper revenues, which summed up to US$ 7.1 billion (figures in 1995 US$).

CONCLUSIONS: Our historical case study is highly relevant for the design and implementation of contemporary malaria control initiatives. In view of fewer adverse ecological effects, increased sustainability and better utilization of local resources and knowledge, environmental management must become a central feature for integrated and sustainable malaria control.

ADDITIONAL AUTHOR: Burton H. Singer

ABSTRACTS

A4
Gender Inequity and Violence: Challenges in the Social Environment

The Impact of Gender Inequality on Safe Motherhood

JILL GAY

LEARNING OBJECTIVES: Participants attending this session will be able to identify some of the key gender issues related to safe motherhood, effective interventions to reduce gender inequality and safe motherhood, and gender inequalities for which no effective interventions have been developed.

BACKGROUND: The intended audience is policy-makers and practitioners in global public health. The issues to be discussed are: policies matter; involve men; women need information, choices and resources; and the gender inequalities that fuel the HIV/AIDS epidemic also threaten safe motherhood gains. There are effective evidence-based interventions that have been shown to reduce the likelihood of HIV transmission while promoting gender equality. Studies from numerous developing country settings have documented effective programs. However, there are gender inequalities that fuel the HIV epidemic for which effective interventions have not been developed, such as norms that sanction gender-based violence or multiple partners for men. Providing antiretroviral therapy to pregnant women beyond the course of pregnancy and delivery can reduce the numbers of AIDS orphans.

CONCLUSIONS: Policies can improve maternal health and combat gender inequalities. Male involvement while respecting women's autonomy is a critical issue. Women need information and choices to empower them in childbirth. Nutrition can be improved through providing women with resources, such as credit and training. Gender inequalities that fuel the HIV and tuberculosis epidemics threaten safe motherhood gains. Gender inequalities can be reduced to improve maternal health and are replicable even in low-resource settings.

ADDITIONAL AUTHORS: Karen Hardee, Kokila Agarwal, Nicole Judice, Anne Eckman

A4
Gender Inequity and Violence: Challenges in the Social Environment

Developing Indicators to Assess Women's Empowerment in Vietnam

DIANA SANTILLÁN

LEARNING OBJECTIVES: Participants attending this session will be able to understand the methodological challenges to assessing empowerment and identify a set of Vietnam-specific domains suitable for assessing women's empowerment.

BACKGROUND: Since the 1994 International Population and Development Conference in Cairo, the population and development field has made considerable progress in transforming policies and programs to promote the goals of gender equity and women's empowerment, along with a broadening array of reproductive health goals. The adoption of these goals presents challenges for impact evaluation. Outcomes such as contraceptive use and fertility are relatively easily measured using standardized indicators. The same is not true for gender equity and women's empowerment — concepts that refer to social relations and processes, and require context-specific indicators.

METHODOLOGY AND RESULTS: From mid-1999 to mid-2001, the authors collaborated in a qualitative study examining relationships between gender, women's empowerment and reproductive health in rural Vietnam. A key objective was to develop culturally appropriate indicators of women's empowerment in Vietnam. The study sites were four rural communes in two Vietnamese provinces. Case studies were based on data from semi-structured, in-depth interviews with 66 married women and 13 of their husbands. The research team developed empowerment indicators and tested them by using them to categorize each woman's level of empowerment in social and economic spheres of life and in reproductive health. The paper describes the process of developing, testing, and refining empowerment indicators and discusses the methodological challenges entailed. 'Agency' and 'process,' two defining elements of empowerment, are not easily captured using standard social science research methods. External factors must be taken into consideration, and a solid conceptual framework is needed.

CONCLUSIONS: As health and development policies and programs expand their focus to include women's empowerment and gender equity, it will be important to continue refining research methods and indicators to measure these complex variables. As a contribution to that process, the paper concludes by recommending a set of Vietnam-specific domains for assessing women's empowerment in social and economic spheres of life and in reproductive health.

PARTNERS: Investment in Health Promotion, John Snow, Inc., Population and Development International

ADDITIONAL AUTHORS: Sidney Schuler, Hoang Tu Anh, Tran Hung Minh, Quach Thu Trang, Nguyen Minh Duc

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A4
Gender Inequity and Violence: Challenges in the Social Environment

A Study on the Prevalence and Magnitude of Gender-Based Violence among Karen-Burmese Refugee Women

BASIA TOMCZYK

LEARNING OBJECTIVES: At the conclusion of the presentation, the audience will be able to: 1) describe the methods used to assess gender-based violence; 2) discuss cultural issues that limit access to reproductive health services; and 3) discuss translation of research into program recommendations.

BACKGROUND: Reproductive health care for the Karen and Burmese refugees has been a primary concern among the international health agencies working on the Thailand-Burmese border. Experience of health-care professionals serving the refugee population indicated that appropriate reproductive health services must address the issue of violence against women.

METHODOLOGY AND RESULTS: Three refugee camps on the Thai-Burmese border with a total population of 70,480 were the setting for the research project conducted by the Centers for Disease Control and Prevention (CDC) during the spring of 2002. The cross-sectional study obtained data from 549 married women of reproductive age (15-49 years). Trained interviewers administered a face-to-face questionnaire that contained questions on violence that were comparable to questions used in other CDC Reproductive Health Surveys. The questions asked about different types of violence, ranging from verbal to sexual. Descriptive analysis is presented on lifetime prevalence of violence. Overall, 31 percent of the sample reported one or more episodes of violence in their lifetime. Among women reporting violence by an intimate partner, physical abuse was the most common, 50 percent, followed by verbal abuse, 34 percent, and then sexual abuse, 16 percent. Among women who reported violence by someone other than an intimate partner, verbal abuse ranked highest, 61 percent, followed by physical abuse, 34 percent, and no reports of sexual abuse. Overall, 17 percent had sustained a physical injury in a violent episode that occurred within the last 12 months. Only 18 percent of the women talked to anyone about a violent incident; the majority told a friend rather than a health-care provider or authorities. When women were asked about their preference for each of these services, 63 percent stated they would prefer community, 71 percent would prefer interventions by religious leaders, and 14 percent stated that the health-care programs could help address the issue.

CONCLUSIONS: Data on violence in refugee populations are scant, despite a general understanding by health-care providers that violence is an issue that frequently affects women in refugee settings. These findings, although most likely underestimated, indicate that violence is prevalent in the lives of Karen and Burmese refugees living in the three selected sites and suggest a need for services to assist abused women. In part based on these data, the refugee community has taken steps to incorporate services to assist victims of violence. However, additional support is needed to sustain these efforts and to broaden them to include a multisectoral approach and emphasize prevention.

PARTNERS: Division of Reproductive Health/CDC, American Refugee Committee

ADDITIONAL AUTHORS: Michelle Hynes, Hoyt G. Wilson, Gary Dah, Mary Kay Larson, Mary Goodwin

LEARNING OBJECTIVES: Participants will learn about identifying occupational and environmental pesticide intoxication.

BACKGROUND: Acute pesticide intoxication constitutes one of the principle problems of occupational and environmental health in Nicaragua. The department of Matagalpa registered an increase in cases of acute pesticide intoxication from 281 cases in 1998 to 318 cases in 1999. The number of deaths resulting from acute pesticide intoxication increased 60 percent, from 15 in 1998 to 37 in 1999. A survey was developed and administered to 105 farmers in the 12 small communities that make up the Río Jigüina watershed between May and July 2000. The survey was used to characterize the population and agricultural production system in the watershed. The objective of the study was to identify the presence, distribution and use of pesticides in the watershed and present this information to local doctors, nurses and health-care workers to aid them in recognizing the signs and symptoms of pesticide intoxication. Results of the survey identified 27 different crops cultivated in the region, 44 pests that attack those crops and 55 pesticides used in controlling the pests. A list of the pesticides used, the specific crops to which they were applied and the time of year they were used was developed with the hopes that local health-care workers would be able to use this list to better identify the specific pesticides and practices linked with pesticide intoxication.

CONCLUSIONS: Recommendations resulting from the study include: continuing education and providing more technical information to farmers; the development of farmer-leaders in the community; implementing an integrated curriculum in the schools concerning the effects of pesticides on health and the environment; and additional training for health-care workers concerning signs and symptoms of pesticide intoxication and treating these cases. Pesticide use, crops cultivated and the composition of the population may vary geographically. Collecting this type of regionally specific information and providing it to local health-care workers may aid in the recognition and treatment of pesticide intoxication.

PARTNERS: Global Health Agency, Association for the Development of Nicaragua

A5
Toxic Exposure: Combating Risk in Urban and Agricultural Settings

A Study of the Presence, Use and Distribution of Pesticides in the Río Jigüina Watershed, Matagalpa, Nicaragua

TOM LUBEN

LEARNING OBJECTIVES: By the end of the presentation, participants will understand the extent of pesticide use and the impact on the health of Hispanic agricultural communities of the Americas. Participants will be able to describe a community-based health education strategy for use with both agricultural workers and the communities in which they live.

BACKGROUND: Pesticide exposure poses one of the greatest challenges for farmers and agricultural laborers because they suffer from the heaviest exposure to toxic chemicals than any worker or consumer group, very often enjoying minimal protection from exposure. In addition to farmers and agricultural laborers themselves, their families and children are exposed to these hazards and child labor compounds these problems. In the developing countries of the Americas, a large portion of the labor force works in agriculture; in the developed countries, a large portion of the agricultural workforce is Hispanic. Hispanic agricultural workers often have poor access to health services even though there is a wide range of potential physical, biological, chemical and other risks encountered in agricultural work. Pesticides are a special category of concern for agricultural workers because of the large spectrum of health effects and the under-reporting of poisoning that occur. Pesticides can be extremely toxic; before they are diluted for application, no more than two or three drops on the skin can be fatal. The risk of accidental exposure from being sprayed, from drift from a nearby field or from re-entry into fields too soon after they have been sprayed shifts to farm workers and their children. Even low-level exposure can cause symptoms that range from rashes, nausea, vomiting and blurred vision, to extreme lethargy and unconsciousness. In many cases, these symptoms are either incorrectly diagnosed or not identified.

CONCLUSIONS: Farmers and farm workers suffer from the heaviest exposure to toxic chemicals of any worker or consumer group. One important tool to remedy this is participatory health education. Communities impacted by the use of agricultural pesticides can be empowered to identify risks and change behaviors through appropriate participatory community health education.

A5
Toxic Exposure: Combating Risk in Urban and Agricultural Settings

Pesticide Education in Hispanic Communities of the Americas

RITA M. MONROY

A5
Toxic Exposure: Combating Risk in Urban and Agricultural Settings

Reducing Exposure to Lead: A Critical Urban Health Problem

CHRIS SMITH

LEARNING OBJECTIVES: Participants will understand the significant health impact of lead in developing urban environments and learn about targeted measures that successfully reduce this threat.

BACKGROUND: A 1994 comparative risk assessment showed airborne lead posed one of the highest health risks in Cairo. Reducing Cairo blood lead levels to natural background levels would significantly improve the mental development of children (about 4.25 IQ points per child) and reduce deaths from cardiovascular illness by 6,300-11,100 per year. (By contrast, extending good water and sewer service to unserved neighborhoods would prevent 1,700-5,500 deaths per year.) Most of the lead in Cairo entered the environment through highly leaded gasoline and lead smelters. Among other initiatives, the government of Egypt quickly reduced the lead content of gasoline and began dealing with lead smelters. Lead concentrations in ambient air around smelters were 10-50 ug/m3 versus the United States health-based standard of 1.5 ug/m3. One lead smelting company, responsible for 70 percent of the industrial lead production in Egypt, was relocated from a densely populated area to a more remote industrial site. A unique sales contract for the new site contained 18 clauses to protect health and the environment. The new smelter is using a new environmentally sound process to significantly reduce emissions. Plans for remediation of the original site are under consideration. As a result of these and other measures, total lead loading to the environment in Cairo dropped by 29 percent between 1999 and 2000; around lead smelter sources, reductions in lead levels in air approach 90 percent.

CONCLUSIONS: Efforts to mitigate industrial pollution threats to human health should start with a comparative health risk assessment to establish priorities. The devastating impact from exposure to lead can be significantly reduced by focusing on the relatively limited number of concentrated industrial sources, such as lead smelters. An effective approach for dealing with lead smelters is relocating them to low population density areas, introducing cleaner technologies, and remediating old sites.

PARTNERS: Egyptian Environmental Affairs Agency, Chemonics International, Environomics, Chemonics Egypt, Stone & Webster, Charles Licht Engineering Associates, CH2M Hill

ADDITIONAL AUTHOR: David Fratt

ABSTRACTS

A6
The Special Vulnerabilities of Children to Environmental Conditions

Improving Children's Environmental Health: From Science to Solutions

KATHERINE M. SHEA

LEARNING OBJECTIVES: By the end of the presentation, participants will understand where further research is needed in order to link environmental exposure to health outcomes in children and some of the projects currently underway. Participants will also understand how this information can be used to create and change policy.

BACKGROUND: The scientific community and health and environment policy-makers know that children are a vulnerable group when exposed to modern society. Children in the developing world are also at risk; environmental hazards result in the deaths of about 5 million children under the age of 5 years each year. New policies based on research and focused on the child are needed to protect future generations. In the United States, a number of federal research and policy initiatives began in the 1990s that emphasized consideration of the special vulnerabilities of children to environmental hazard. New information on childhood exposures, and pediatric toxicities are being used to develop more precise regulatory responses that improve protection for children. Some of these initiatives will be reviewed. Research is still needed in different areas related to children's environmental health. We still don't know enough about the origins of childhood cancer, the causes and effects of neurological childhood diseases and disorders, the effects of noise, heavy metals or endocrine disruptors on children.

CONCLUSIONS: Children emerged as a vulnerable group in society that has been neglected by many generations. Still many children suffer from lack of basic needs in life, such as clean water, good sanitation, clean air, good housing, adequate waste disposal and good education. Also modern hazards such as toxic substances endanger children's health, by either unsafe use of chemicals or environmental degradation. New emerging global problems, such as climate change or endocrine-disrupting chemicals, are affecting children's health and development. New research aimed at specific targets, regulations protecting children's health, policies preventing problems along with tools aiming at education and communication are needed urgently to safeguard the health and well-being of future generations.

A6
The Special Vulnerabilities of Children to Environmental Conditions

Children's Special Vulnerabilities to Chemicals

LILIAN CORRA

LEARNING OBJECTIVES: By the end of the presentation, participants will understand why children are vulnerable to chemical exposure, the most common chemicals of concern, the potential health outcomes of exposure, the importance of the timing and extent of exposure, and the information gaps that exist.

BACKGROUND: Chemicals, including pesticides and persistent organic pollutants (POPs) can be hazardous to children's health. Children are highly exposed and extremely vulnerable to chemicals and pesticides due to unique behaviors and constant state of growth. Children tend to explore environments, spend a great amount of time on the ground where chemicals settle, and engage in frequent hand-to-mouth activity. Children eat more food, breathe more air, drink more water and have a large skin surface area relative to body weight compared to adults. The child's developing physiologic systems are also less able to detoxify pesticides. All of these factors make children more vulnerable to chemical exposure. Children's tissues, organs and physiologic systems are undergoing rapid growth and development. Exposure to pesticides during this critical period increases the potential for damage to the development of motor activity, cognitive ability and emotional and social development. Low-level exposure by a developing fetus, infant or young child to certain commonly used pesticides can cause adverse effects, including developmental and reproductive effects, neurological and behavioral disorders, endocrine disruption, immune disorders and cancer. Exposure to extremely low levels of some POPs can alter the function of the endocrine system. POPs have also been implicated in adverse effects on cognition, precocious puberty, female reproductive problems, declining male sperm counts and malformations of the penis and testicles.

CONCLUSIONS: Research is needed in order to fully understand the links between chemical exposure and health outcomes in children. Education of the public health community, government officials, policy-makers and the general public is essential to bring about a decrease in unnecessary chemical use and a use of the least toxic chemicals. The Stockholm Convention on POPs calls for the elimination of the 12 most dangerous POPs, but has not yet entered into force. We know that chemicals can cause serious health problems in children worldwide. With that knowledge, society needs to move forward to limit exposure to chemicals. This can be accomplished at local, national, regional and international levels.

PARTNER: International Society of Doctors for the Environment

ADDITIONAL AUTHOR: Karen Hopfl-Harris

A6
The Special Vulnerabilities of Children to Environmental Conditions

Why Healthy Children Require Clean Water and Sanitation

VANESSA TOBIN

LEARNING OBJECTIVES: By the end of the presentation, participants will understand the extent of the water and sanitation problems that face children worldwide, some of the countries and regions where problems are particularly challenging, the health outcomes caused in whole or in part by poor water and sanitation facilities, and overall solutions needed.

BACKGROUND: Each year the health of millions of young children is compromised by poor environmental conditions. Diarrhea accounts for 17 percent of childhood mortality and despite improvements in the past decade, diarrhea still claims the lives of nearly 2 million children every year. Between 80 and 90 percent of these diarrhea cases are related to environmental conditions, particularly contaminated water and inadequate sanitation. Approximately 1.1 billion people do not have access to clean and safe water supplies, and about 2.4 billion people lack sanitation facilities. Water quality compromised by harmful substances such as arsenic and biological agents also affects child health, and these problems are widespread. UNICEF has for many years been working to educate about these problems and potential solutions, from better hygiene practices, to improved water storage and treatment, to oral rehydration therapy, to improved environmental conditions.

CONCLUSIONS: Sustained education and public health training, improved environmental conditions and access to targeted indicators of environmental health problems will go a long way toward improving the health of children affected by poor water and sanitation facilities. Diarrheal disease can result in poor nutrition, anemia, retarded growth and death due to acute dehydration. Without coordinated and dedicated action on the part of governments, international agencies and public health experts to invest in the tools needed to solve this problem, millions of children across the world, specifically in the poorest parts of the world, will continue to suffer needlessly. UNICEF is committed to leading the movement to tackle these water-related problems for the benefit of children.

PARTNERS: Project staff, community project organizations

ADDITIONAL AUTHOR: Karen Hopfl-Harris

A7
Health Sector Reform and Financing: Resources and Expenditures

Decentralization and Equity in a Federal Country, Argentina

DANIEL MACEIRA

LEARNING OBJECTIVES: Participants attending this session will be able to understand advantages and disadvantages of the decentralization reform implemented in Argentina, its effects on equity and the role played by national and provincial authorities related to goal definition and fund management.

BACKGROUND: Health-care coverage in Argentina is shared between the public sector, the social security institutes and the private sector, closely intertwined in terms of both health-care provision and social security financing and coordination. Since the beginnings of the 1990s, a strong decentralization process took place when the national governments transferred to the provinces the funds and the ownership of public hospitals and health centers, keeping the management of vertical programs and special initiatives. Under the nation's institutional federal framework and considering wide differences in wealth and health-care indicators among provinces, the goal of the study is to search for differences in utilization and expenditures patterns between jurisdictions and income quintiles. The research also inquires about the ability of the national government to compensate local differences.

METHODOLOGY AND RESULTS: The study uses demographic and financial data at national and provincial levels related to health-care expenditures during the period 1993-2000, in order to identify expenditure gaps at the provincial level. Moreover, information from household surveys on services utilization and out-of-pocket expenditures in health services and pharmaceuticals was analyzed, providing a comparative analysis by income groups. As a result, the study shows weak correlations between provincial public funds and population needs, as well as a strong bias toward expenditures on pharmaceutical products, as percentage of total private expenditures on health. Results show that despite the federal nature of the country, the central government still accounts for a significant share of the public expenditures in the sector, mainly focused on disadvantaged groups, although without a significant redistribution strategy.

CONCLUSIONS: Decentralization in a federal developing nation such as Argentina provides useful information related to the definition of health care priorities and to the allocation of results between different governmental levels. The study suggests that provincial autonomy requires strong coordination of goals in order to reach national equity and assure financial sustainability.

ABSTRACTS

A7
Health Sector Reform and Financing: Resources and Expenditures

Social Health Insurance for Sub-Saharan Africa

MARTY MAKINEN

LEARNING OBJECTIVES: Participants attending this session will: 1) understand what social health insurance (SHI) is; 2) know what sub-Saharan African health problems can and cannot be addressed by SHI; 3) learn what factors contribute to and what complements may be added to SHI to enhance success; 4) learn what African countries are doing concerning SHI; and 5) understand the potential for SHI in sub-Saharan Africa.

BACKGROUND: This paper provides a summary of the state of knowledge concerning SHI, its potential and its limitations for sub-Saharan Africa as many countries embark on and others consider whether and how to implement it.

METHODOLOGY AND RESULTS: The paper is based on an extensive review of published and unpublished 'gray' literature. The paper poses and answers eight key questions about the feasibility and limitations of SHI in sub-Saharan Africa. It reviews and analyzes the state of preparation or implementation of SHI in Ghana, Kenya, Nigeria, Tanzania, South Africa and Zimbabwe. The SHI programs are analyzed in terms of eligibility and structure, type of contribution, population covered, benefits package, provider contracts and payment methods, design innovations, what has worked/not worked and risks for scheme success.

CONCLUSIONS: While SHI has the long-term potential to be the major source of financing for health care in the near-term, SHI can only cover a limited population, i.e., formal sector workers and dependents. Most countries will need to create institutions (SHI fund, collection mechanism, accreditation unit, monitoring, evaluation and policy analysis unit for SHI) and strengthen capabilities (administrative and analytical) to handle SHI in advance of its implementation. A number of technical analyses should be performed before SHI is implemented. Political support must be built for SHI. SHI should be placed within an overall health-care financing policy that addresses how populations SHI cannot cover in the near term will be addressed.

PARTNERS: USAID's Regional Economic Development Support Office for East and Southern Africa

ADDITIONAL AUTHOR: Bryn Sakagawa

LEARNING OBJECTIVES: Participants attending this session will be able to establish the gaps in cost recovery for health-care delivery system and understand factors responsible for efficient cost recovery.

BACKGROUND: Health sector reform in Kenya places strong emphasis on cost sharing. However, cost sharing is a futile exercise if good governance is not established, and financial systems remain inefficient and unaccountable. This study, therefore, examines the efficiency of cost recovery at a government dispensary and examines factors responsible for inefficiencies.

METHODOLOGY AND RESULTS: A descriptive cross-sectional study using existing financial and medical records was carried out in selected government dispensaries providing primary care services in two rural districts in Kenya. A focus group discussion was carried out with staff and community elders to establish the factors leading to inefficiency. The records showed that a total of 29,947 patients registered in one year. A minimum fee charged per patient is Kenya shillings (Kshs) 10. Therefore, the expected collection should have been Kshs 299,470 (US$1 = Kshs 78). However, the actual amount collected was Kshs 76,000, which is 25 percent of the expected collection. There were no records of fees collected or exemptions given to the poorest. The village elders confirmed that no exemption was ever given to any patients from their villages.

CONCLUSIONS: Cost recovery at the Ministry of Health dispensary had been highly inefficient since three-fourths of the expected revenue was lost. While health sector reform emphasizes cost recovery, it is clear that recovery remains inefficient if an effective and transparent financial system is not in place. In the absence of an efficient and transparent financial system, the poorest segment of the population ends up being taxed, who in the first place should be exempted. The health care reform should first emphasize establishing efficient systems before initiating cost recovery.

PARTNER: Ministry of Health, Coast Province, Kenya

ADDITIONAL AUTHORS: Arntz Claudia, Swafiya M. Salim

A7
Health Sector Reform and Financing: Resources and Expenditures

Cost Recovery Is Futile without Transparent Financial Systems

SALIM B. SOHANI

ABSTRACTS

LEARNING OBJECTIVE: Participants will be able to: 1) Identify how an entertainment education (EE) program is designed, developed and produced; 2) recognize the advantages of using EE for promoting health-related behavior change; and 3) evaluate key lessons learned from the Bangladesh EE programs and then apply these to participants' own work.

BACKGROUND: With less than 40 percent of the population in Bangladesh having access to basic health and 75 percent of pregnant women not receiving antenatal care, improvements in family health are much needed. Two highly popular EE serial dramas were recently produced, with the aim of addressing this issue. Each serial weaves in health topics with a compelling storyline to yield popular, educational drama. Highlighting the key lessons learned and impact of these social dramas, 'Under the Green Umbrella: Social Dramas for Health,' a documentary video, succinctly illustrates the EE development process and will be shown to participants as part of the EE presentation. Through interviews with key players, the scriptwriter, actors, viewers and field workers along with clips from the two most popular dramas, 'Shabuj Shathi' and 'Shabuj Chhaya,' the video brings to light the value of EE drama and how others can benefit from this technique.

CONCLUSION: Using television drama to promote integrated health services and providers is a highly effective behavior change communication (BCC) tool. Through impact evaluation data, the Bangladesh dramas captured more than 40 million viewers and consistently received high television ratings. Positive health-seeking behaviors resulted from each of the dramas. The process for developing EE dramas is very unique and not well documented. From stakeholder meetings to health topic selection, message development and design, EE is a health education tool useful for any health professional interested in social change.

PARTNERS: Christy Kelly, Bangladesh Center for Communication Programs, Johns Hopkins University Center for Communication Programs, Ministry of Health and Family Welfare of Bangladesh, USAID

ADDITIONAL AUTHORS: Mohammad Shahjahan, Esta de Fossard

Using the Arts in Health Interventions

Under the Green Umbrella: Social Dramas for Health

EDSON WHITNEY

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B1
Supply and Demand: Addressing Challenges in Health Service Delivery

The Silent Crisis of Health Human Resources in Africa

A. EDWARD ELMENDORF

LEARNING OBJECTIVES: By the end of the session, participants will be able to understand the thus far largely silent crisis of inadequate health human resources in Africa, and the importance of actions to address it by African Ministries of Health and other government agencies, professional organizations, Africa's development partners within the framework of their cooperation with African countries and OECD country governments. It is expected that participants will be able to contribute their own perspectives during the discussion.

BACKGROUND: Human resources are widely recognized to be the most important input into the provision of health care. For many years, African countries have invested in the training of additional personnel, but few governments have paid sufficient attention to the motivation, professional development and deployment of existing staff. As the labor market for skilled personnel has become increasingly flexible worldwide and economic stagnation has continued, emigration of Africa's trained health-care staff has become widespread. The HIV/AIDS pandemic is placing profound stresses on current health-care providers and decimating staff. Yet, health human resources issues have received little attention in the design and implementation of health sector reform programs. The need for change has received little attention in the curricula for training of African health personnel. In January 2002, the World Bank and the African Regional Office of WHO, in cooperation with UNESCO, organized a consultative meeting on these issues in Addis Ababa, Ethiopia. Seventeen African country delegations participated, with teams from Ministries of Health, Education, Finance, Planning and Civil Service, as well as professional organizations.

CONCLUSIONS: The Addis Ababa consultative meeting found that the situation of health sector human resources was reaching crisis stage. It underscored the importance of new partnerships between the health and education sectors, of engaging the health professions in health policy formulation and implementation, and of improving the environment in which health-care providers work in Africa. Key development partners have resolved to work with African countries to address these and other health human resources issues. Without urgent and sustained action on them, investments in improved health outcomes cannot and will not achieve better health in Africa.

PARTNERS: WHO/African Regional Office, Academy for Educational Development/SARA Project

ADDITIONAL AUTHORS: John M. Bryant, Gilles Dussault, Demissie Habte, Stephen Kinoti, Bernard Liese, Oscar Picazo, Khama Rogo

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B1
Supply and Demand: Addressing Challenges in Health Service Delivery

Trust Between Traditional Healers and Health Workers Makes Better Health

MUTINTA NYUMBU

LEARNING OBJECTIVES: Participants attending this session will be able to start up a program where traditional healers work with health workers to improve the health of clients.

BACKGROUND: In Zambia, traditional healers continue to play a significant role in health care provision and in shaping the social environment for people. It is estimated that 80 percent of the population consult traditional healers on matters of health, finances and others. Capitalizing on the role that traditional healers play, Zambia Integrated Health Programme, a USAID/Zambia Ministry of Health-funded project, and a 50,000-strong Traditional Health Practitioner's Association of Zambia used the traditional healer-community health center networks to improve the health outcomes of communities. Several group-building consultative meetings were held initially to build trust between traditional healers and health workers. Using a training manual in the local languages developed by the partners, traditional healers have been trained in timely referral of cases to health centers and in basic information on water/sanitation, HIV/AIDS, malaria, child health, nutrition and tuberculosis. Using a case study approach, a tag team of 225 traditional healers and 75 health center staff from the same catchment areas in five districts were trained and in turn will train other traditional healers. This innovation in training has not only provided technical information with the potential to reduce mortality, it is also building the trust between the two groups and strengthening the social capital of cooperation. Trained traditional healers are now able to distribute condoms, sell clorin (a water treatment product), retreat and sell insecticide-treated nets and oral rehydration solution, give integrated health education messages, refer patients to health centers, and submit monthly reports to health centers.

CONCLUSIONS: Traditional healers are potential partners in the delivery of health care services to the community. They are trainable using appropriate methodologies. They reach out to more people than health centers. An environment of mutual trust needs to be built between traditional healers and health workers before the two can work together.

PARTNERS: Ministry of Health, Traditional Health Practitioner's Association of Zambia, Central Board of Health, USAID

ADDITIONAL AUTHORS: Edith Bwalya, Nosa Orobaton, Chilandu Mukuka-Chilaika

LEARNING OBJECTIVES: Participants attending this session will be able to identify how rural men and women see changing gender norms and understand how recent health policies support women's autonomy.

BACKGROUND: In 1997, NGOs in Bangladesh discontinued household contraceptive distribution in favor of integrated service delivery. Many feared that inequitable gender norms would make it impossible for women to use the reconfigured services. Informal debates continue about whether USAID is undermining service access by forcing NGOs to move too quickly to clinic-based services.

METHODOLOGY AND RESULTS: The paper combines data from two qualitative studies: on changing gender norms and utilization of health services (1998-2000); and on roles of health and development policies in reducing gender-based inequities and supporting reproductive health (2000-2002). Results from a thematic analysis of approximately 350 in-depth interviews and focus groups show that ordinary people in rural Bangladesh have considerable insights into the effects of social policies on gender norms. Many described changes in women's nature and behavior, saying that women were becoming 'smarter.' They explained this phenomenon in terms of adaptation to intensifying problems such as poverty, population growth, environmental deterioration and disease, but also as a response to new opportunities, including the increased availability of health and family planning services, education and micro-credit. They see the 'smart woman' as a product of these opportunities as well as a result of the greater exposure to the world outside the home entailed in pursuing them.

CONCLUSIONS: Much of the literature on the Bangladesh family planning program has construed gender inequality as an obstacle to the adoption and widespread use of contraception; the initial response was to work around these obstacles by delivering contraceptives to homes. Our findings suggest that women were not nearly as dependent on home distribution as many had feared, and that this service strategy had become unnecessary. As service delivery shifts from the home to the clinic, the now widespread acceptance of family planning becomes one more factor drawing women into the public sphere. Both men and women recognize that women's 'emergence' from the home changes women and alters gender relations.

PARTNER: John Snow, Inc.

ADDITIONAL AUTHOR: Carol Boender

B1
Supply and Demand: Addressing Challenges in Health Service Delivery

Bangladesh's Health Policies and the Emerging 'Smart Woman'

SIDNEY RUTH SCHULER

LEARNING OBJECTIVES: Participants will better understand the causes of food insecurity and methods for addressing threats. Participants will be introduced to successful methods for disseminating accurate and timely early warning information, utilizing the vulnerability analysis, strategies for strengthening country and regional networks, African capacities and decision-making and response planning.

BACKGROUND: Regrettably, sub-Saharan Africa still faces natural and man-made threats that, in the extreme, could lead to famine. Climatic, socioeconomic and demographic changes that can adversely affect food availability and/or access to food in the short-run need not pose serious acute food security threats. Furthermore, countries moving away from highly food insecure situations, particularly those in post-conflict settings, have opportunities to improve their short- and long-term food security environment. Finally, countries facing slowly deteriorating chronic food insecurity conditions have opportunities to arrest these declines. The Famine Early Warning Systems Network (FEWS NET) is the principal activity in this food security information-based approach to preparedness and planning. FEWS NET is creating more useful and sustainable information systems that facilitate finding solutions to food insecurity problems in sub-Saharan Africa. The focus of FEWS NET is to empower Africans to find African-led solutions to African-identified food insecurity problems. By strengthening African capacity to improve the quality and effectiveness of food security information systems and networks, we are helping to eliminate avoidable famines. To meets its many objectives, FEWS NET is using the following approach: continued production of high-quality information for disaster/crisis prediction, strengthen contingency and response planning, emphasis on developing sustainable networks, emphasis on policy-useful information and continued innovation in analytical tools and methods. The results have been relevant information being used in the development of policies, programs, strategies and plans that reduce food insecurity.

CONCLUSIONS: While certain crises come without warning, anticipated and gradually unfolding natural disasters often provide ample time for decision-makers to prepare and take preventive action.

PARTNERS: Chemonics, NASA, USGS, USDA, NOAA

B2
In the Face of Famine: Increasing Food Security in Sub-Saharan Africa

Improving Food Security in Africa

CHARLES CHOPAK

B2
In the Face of Famine: Increasing Food Security in Sub-Saharan Africa

Food Security and HIV/AIDS

ROY STACEY

LEARNING OBJECTIVES: Participants will have a better understanding of both how access to food is affected by HIV/AIDS, and how HIV/AIDS is a consequence of the way poverty plays itself out in different geographic settings.

BACKGROUND: HIV/AIDS is different from other diseases because it is debilitating at first, fatal in the end and affects adults in the prime of their productive lives. The subsequent economic effects of HIV/AIDS at the household level are multiple and far-reaching with knock-on effects at every level of the micro- and macroeconomy. The Famine Early Warning Systems Network (FEWS NET) is the principal activity in this food security information-based approach to preparedness and planning. FEWS NET is creating useful and sustainable information systems that facilitate finding solutions to food insecurity problems in sub-Saharan Africa. Through employing a livelihood-based approach, FEWS NET helps to highlight the specific economic effects of HIV/AIDS at the household level, and helps provide an understanding of the consequences of these effects on access to food. By understanding the economic shocks caused by HIV/AIDS in the context of food economy baseline work, FEWS NET contributes a better understanding of both how access to food is affected by HIV/AIDS, and how HIV/AIDS is a consequence of the way poverty plays itself out in different geographic settings. In the short term, the most immediate impact is likely to be increased impoverishment due to the loss of productive and financial assets, i.e., loss of income-earning labor, loss of household assets and increased health care and funeral expenses. In the longer term, the negative catalytic effects and widely systemic impact of the epidemic are likely to amplify existing food insecurity problems and will almost surely trigger long-term structural changes, creating new as-of-yet unidentified food security problems.

CONCLUSIONS: Studies have provided a better understanding of how HIV/AIDS affects food security issues. Results highlight the far-reaching impacts of the disease and provide essential information for adequate food security planning and preparation.

PARTNERS: Chemonics, NASA, USGS, USDA, NOAA

ADDITIONAL AUTHOR: Tanya Boudreau

ABSTRACTS

B2
In the Face of Famine: Increasing Food Security in Sub-Saharan Africa

Vulnerability to Food Insecurity and Malnutrition in Ethiopia: A Multilevel Analysis

CHARLES H. TELLER

LEARNING OBJECTIVES: Participants attending this session will be able to identify the main risk factors and causes of chronic vulnerability to food insecurity and malnutrition in poor countries such as Ethiopia.

BACKGROUND: Ethiopia is one of the few countries in the world with annual emergency appeals for food aid. Currently (February 2003), there are 11-14 million people estimated to need food aid by mid-year. A majority of these are not acutely, but chronically, food insecure and undernourished. Their physical and social environments predispose them predictably to being highly vulnerable to seasonal shocks. Much of the data used to identify and target these vulnerable people have traditionally come from secondary sources and rapid appraisal methods, but these sources are continually questioned for reliability. The objective of this study is to understand and analyze the main risks factors, causes and local capacities related to chronic vulnerability to food insecurity, malnutrition and epidemic in drought-prone areas of Ethiopia, through systematic and reliable primary data collection. Moreover, practical policy and program recommendations are made to the government and international donors on how to reduce dependency on food aid. The study was conducted by the Ethiopian Disaster Prevention and Preparedness Commission, with funding from USAID.

METHODOLOGY AND RESULTS: The study design included a multistage stratified random sample in 16 districts and 93 communities around the country. The sample size was nearly 10,000 households, 9,700 women of reproductive age and 4,000 children aged 3-36 months. It also included 1,300 key informants and 93 community group discussions. The data collection methods consisted of three different and triangulated sources of data: cleaned secondary multisectoral data; primary rapid rural appraisal and primary household and women's survey; and women's and child anthropometry. The data were collected in February and March of 2000 through established regional, zonal and district research teams. The findings indicate that chronic food insecurity was identified as the most important problem faced by these rural communities, and that there was an average food self-sufficiency period of only seven months per year. Compared to the nationwide DHS 2000 level of young child stunting of 53 percent and under-five mortality of 188, most of the sampled drought-prone districts had levels considerably higher than this. Five sets of multilevel ecological, community and household risk factors and causes were identified and weighted: drought risk, demographic/environmental stress, no access to basic services, asset depletion/irreversible coping strategies and institutional and policy inadequacies.

CONCLUSIONS: Chronic vulnerability varies significantly within districts, agro-ecological zones and communities. This demonstrates that more reliable and useful primary data can be collected efficiently to help identify the chronically food-insecure communities and households, and target them for longer-term disaster prevention and mitigation strategies that can reduce the dependency on annual external food aid donations.

PARTNER: Ethiopian Disaster Prevention and Preparedness Commission

ADDITIONAL AUTHORS: Asfaw Yitna, Kefene Asfaw

B3
Taking Child Health Services to Scale

Strategic Concepts and Programmatic Underpinnings of Madagascar's Scaled-Up Family Health Program

NANCY HARRIS

LEARNING OBJECTIVES: By the end of the presentation, participants will be able to discuss the tactical choices, best practices and lessons learned in a successful scale up and integration of child health and reproductive services.

BACKGROUND: Ever since John Snow closed off a London pump that was transmitting cholera in the late 1850s, public health professionals have strived to achieve the best services for the largest number of (vulnerable) people and to use science-based evidence to control or conquer the illnesses and malnutrition that continue to plague humankind. But somewhere between the global conferences in Cairo and Beijing, we partially lost our way. The conferences appropriately underscored human rights aspects of health care and the relationship between quality of care and choice. Unfortunately, it also led to a flowering of small 'boutique' programs that can neither be replicated nor brought to scale. To make matters worse, we are clearly losing the war on ill health and AIDS, especially in Africa. The Jereo Salama Isika Project, led by John Snow, Inc. (and working hand-in-hand with Linkages), has determined to reverse this programming trend. While maintaining quality of care, the project seeks impact on district, regional and national levels. This presentation will examine several strategic concepts and programmatic elements behind its scale-up program, along with evidence of their usefulness. These include: simplifying messages and standardizing IEC (information, education, communication) materials, health cards and job aids; use of large numbers of unpaid volunteers; utilizing client utilization patterns to determine services offered (e.g., four-method family planning); use of task forces and other methods to leverage multiple partners; mobilizing youth; multiplying channels for health promotion; standardizing in-service and pre-service training; and integrating child health and reproductive health.

CONCLUSIONS: Large-scale programs require effective community mobilization coupled with carefully streamlined technical interventions.

PARTNERS: John Snow, Inc., Ministry of Health, Linkages

ABSTRACTS

B3
Taking Child Health Services to Scale

Working at Scale on Integrated Nutrition and Health Through CARE/India's Program

T. USHA KIRAN

LEARNING OBJECTIVES: By the end of the presentation, participants will be able to discuss the best practices and lessons learned in child health and nutrition, in a large PVO-government collaboration taken to scale in India.

BACKGROUND: This program reaches about 10 million women and young children in eight states with a package of nutrition and health services through two national programs, ICDS (integrated child development services) and reproductive and child health. Starting in 1996, the program streamlined its focus on selected interventions, including immunization, nutrition and newborn care. The program platform consists of community-based child care and preschool education centers staffed by two workers, plus an auxiliary nurse-midwife (ANM) who provides outreach health services monthly in each community in addition to health center-based services. A food supplement is provided as an incentive for participation. The program focuses on under-twos, and has developed a set of age-appropriate messages and services that are reinforced by a cadre of volunteer 'change agents.' Community-based organizations, particularly women's groups and village councils, play an important role in supporting the work of change agents, ICDS workers, and the ANM. Program innovations and best practices are transferred through district-based teams that work with 'demonstration sites' to adapt and demonstrate program approaches, tools and frameworks. Approximately 7-10 percent of all communities are demonstration sites, with the remaining sites designated as 'replication sites.' CARE engages local NGOs to assure adequate supervision and support at demonstration sites. Several innovations introduced by NGOs in this program have been adopted nationwide. The key factors for achieving scale in this program include: close PVO-government collaboration; convergence across two major programs with buy in from both sectors to the basic program principles; a streamlined package of interventions with appropriate tools and materials for use over a large and diverse program area; highly motivated district-based teams with flexibility and resources; and a reasonable ratio of demonstration-replication sites that are clustered to achieve rapid diffusion or replication.

CONCLUSIONS: Government and NGOs have complementary strengths that are needed for achieving results in a large program.

PARTNERS: CARE/India, ICDS, Ministry of Health, local NGOs

B3
Taking Child Health Services to Scale

Lessons Learned from Scaling Up the Vitamin A Supplementation Program in Nepal

RAM SHRESTHA

LEARNING OBJECTIVES: By the end of the presentation, participants will be able to discuss the best practices and lessons learned in child health and nutrition, in a large PVO-government collaboration taken to scale in Nepal.

BACKGROUND: The National Vitamin A Program (NVAP) of Nepal was established in 1993, initially covering the districts with the highest prevalence of vitamin A deficiency and later expanding nationwide. Supplementation is carried out twice annually in April and October. It is managed and implemented by the national Ministry of Health and, supplements are administered by female community health volunteers (FCHVs). Key factors in the successful scaling up of this program include: sustained high-level commitment to the intervention and the approach; broad multisectoral participation and innovative mechanisms to support the FCHVs, establishment of a national NGO to provide technical support and monitoring; use of mini-surveys after each distribution round that help identify problems early and keeps the focus on high coverage.

CONCLUSIONS: Community mobilization, sustained policy-level commitment and sustained support are key elements for successful programs.

PARTNERS: Nepali Technical Assistance Group, Ministry of Health, USAID, UNICEF

B4
The Persistence of Inequity: Current Trends in Reproductive Health

Persistent Inequalities in Reproductive Health Services

DUFF GILLESPIE

LEARNING OBJECTIVES: Participants attending this session will be able to learn how the poorest quintile of developing countries has not had access to reproductive health services, and this situation has improved little over the last several decades. Characteristics of the services available to the lowest quintile and its reproductive behavior will be compared to the highest quintile. The presentation will provide explanations for why these inequalities have persisted.

BACKGROUND: The poorest of the poor have always been ill-served relative to higher socioeconomic strata. Appreciating this inequity, donors, NGOs and host-country governments have sponsored programs focusing on the poor. While great gains in public health have been realized in the last two decades, these gains have masked the relative lack of progress in serving the poor. Using multivarient analysis, this study shows that services available to the poor and the characteristics of the poor are responsible for this inequity.

METHODOLOGY AND RESULTS: Reproductive behavior varies greatly from country to country. Egypt has a contraceptive prevalence of 54 percent while Kenya's is 32 percent. However, Kenya's highest quintile is 50 percent, about the same as Egypt's prevalence, while its lowest quintile is 13 percent. Egypt's highest quintile is 61 percent; its lowest 30 percent. If prevalence in these and other countries reached that of their highest quintile, the impact would be profound. Ten countries with two or more demographic and health surveys are analyzed over time in terms of socioeconomic characteristics, desired fertility, reproductive behavior and access to reproductive services.

CONCLUSIONS: This study has significant policy and programmatic implications. Traditionally, emphasis has been placed on changing the reproductive knowledge, attitudes and behavior of the poor. Such things as low contraceptive use and immunization coverage are assumed to be due to the characteristics of the population. This study indicates that it is important to change the way the needs of the poor are programmatically addressed.

PARTNERS: Demographic Health Survey, Macrointernational

ADDITIONAL AUTHOR: Scott Radloff

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B4
The Persistence of Inequity: Current Trends in Reproductive Health

Rapid Health Services Expansion Through Performance-Based Grants

LAURENCE LAUMONIER-ICKX

LEARNING OBJECTIVES: Participants will learn about how a performance-based grants mechanism can be used to coordinate donor resources and rapidly expand health services to underserved communities in countries where the health infrastructure has been destroyed or is severely limited in reach.

BACKGROUND: Afghanistan's history of war and instability has had detrimental effects on the country's health infrastructure and the health of Afghan women, men and children. One out of every four children dies of preventable causes before the age of five years. One woman dies every half-hour due to pregnancy-related causes. With support from the United States Agency for International Development (USAID) and the Ministry of Public Health, Management Sciences for Health developed and implemented a quick-impact performance-based grants program to distribute financial and technical support to local Afghan and international organizations currently providing primary health care to women and children in underserved rural areas to rapidly expand and improve their programs. To date, grants totaling more than US$1.3 million have been awarded and additional proposals await future funding commitments. Activities being supported focus on: expanding access to a basic package of services to areas with few or no health services currently available; expanding the breadth and quantity of services at existing facilities; minor rehabilitation of facilities; training of new and updating skills of community health workers at the community level, with an emphasis on training women; support to maintain or improve the current quality of care; and management strengthening of Afghan NGOs in underserved areas to plan, implement and monitor health activities.

CONCLUSIONS: Developed within the Ministry of Public Health's guidelines and in collaboration with the World Bank and other donors, the performance-based grants have created a transparent and rapid mechanism for coordinating and distributing donor resources to underserved areas of Afghanistan. At the same time, links are being established between organizations providing services and the Ministry of Health, which will serve as the basis for future development of the health system. The lessons learned from this experience in Afghanistan have implications for other countries where prolonged conflict has disrupted health services.

PARTNERS: Afghanistan Ministry of Public Health, USAID, Management Sciences for Health, World Bank

ADDITIONAL AUTHORS: Cynthia Walker, Katie Sears

ABSTRACTS

B4
The Persistence of Inequity: Current Trends in Reproductive Health

The Impact of the Social Environment on Legitimization of Women's Morbidity

ALPANA SAGAR

LEARNING OBJECTIVES: Participants attending this session will be able to understand the place of social values in defining perceptions of morbidity as well as the health-seeking behavior of women.

BACKGROUND: As part of a larger research study exploring the impact of social circumstances on pregnant women's health, this study looked at the impact of the social definitions of health on assessment of women's morbidity.

METHODOLOGY AND RESULTS: A simple random sample of a slum population was taken along with a purposive sampling of pregnant women as they became pregnant. Data were collected by observational techniques, informal discussions, focus group discussions and semi-structured and structured survey schedules. Qualitative data were collected through case reports and case studies.

CONCLUSIONS: The interrelationship between poverty, the social environment and morbidity is well documented. However, in addition to being a cause of morbidity, the social environment also contributes to the lack of recognition of the extent of women's ill health. Using data from a study in a slum in Delhi, India, it was demonstrated that the definition of the 'sick role' by figures of authority does not necessarily relate to women's own perceptions of morbidity. Despite their personal experience, women's ill health has to be socially accepted before it becomes 'real,' and it is these figures of authority in their social milieu, as well the medical professionals, who have the power to legitimize or negate their illness. Much of the burden of women's morbidity is therefore missed in medical work, which gives little if any weight to experiential health. In addition, the social definitions of women's health influence the choices they make when seeking care. The women's economic status and their roles as caretakers of the family take a crucial role in their health-seeking behavior. It is thus indicated that in many instances it may be desirable to change the public health paradigm from the bio-individual to the social level because some of the most powerful forces that affect changes in the disease patterns and health of populations, as well as in health-seeking behaviors, can often operate at this level. Although the discussions in the article are mainly rooted in the Indian social and cultural context, the conclusions drawn here should also be applicable in a more general sense to many other parts of the world, both in the lesser industrialized as well as in the industrialized nations.

B5
Community Participation for Youth Reproductive and Sexual Health

Communities Take Action for Youth in Burkina Faso

NICOLE CHEETHAM

LEARNING OBJECTIVES: Participants attending this session will be able to understand how community participation can improve youth reproductive and sexual health.

BACKGROUND: Youth often lack access to the information and support needed to make responsible decisions about their reproductive health. Many programs fall short of adequately addressing youth needs because they target youth without involving young people or taking their environments into consideration. Over the past four years, Advocates for Youth has been working with Wwangaza and three youth associations in southern Burkina Faso to mobilize communities toward identifying adolescent reproductive health issues and strategies. Based on approaches developed by Save the Children and the National Cooperative Business Center, the youth associations further developed a methodology for mobilizing their communities around adolescent reproductive health. The methodology is characterized by a series of participatory workshops carried out with village committees comprised of girls, boys and adult women and men, village assemblies, regular meetings with local authorities, focus groups and community action planning. As a result of the community mobilization process, boys and girls, with the support of village elders, identified priority issues that include lack of information on sexually transmitted diseases (STDs)/HIV, family planning and female genital mutilation, infrequent use of services and lack of parent-child communication. The strategies that were identified to address these concerns include peer education, parent-child communication, IEC (information, education, communication) and youth-friendly services. Subsequently, community interventions based on these strategies were launched and preliminary evaluation results show improvements in adolescent reproductive knowledge, attitude and practice (KAP) indicators, organizational capacity indicators as well as high levels of participation by community members.

CONCLUSIONS: Through a community participation approach, programs can better serve youth by involving youth themselves and other community members, including parents, teachers, religious leaders and health-service providers, to create an enabling environment that allows and encourages young people to take charge of their reproductive and sexual health.

PARTNERS: Mwangaza, Association Pour Le Développement De La Région De Bittou, Reseau Des Jeunes De La Sissili Et Du Ziro, Association Des Jeunes Pour Le Développement De Pama, the Pacific Institute For Women's Health

ADDITIONAL AUTHORS: Roger Thiombiano, Sylvain Ki

B5
Community Participation for Youth Reproductive and Sexual Health

Community Support for Youth Reproductive Health in Nepal

SANYUKTA MATHUR

LEARNING OBJECTIVES: Participants attending this session will be able to articulate beneficial strategies to build adult support for youth reproductive health programs.

BACKGROUND: In South Asia, parents play an important role in the lives of young people. Strategic involvement of parents can be critical in building a supportive environment for youth reproductive health programs. This study tests the effectiveness of the participatory approach and community mobilization among both youth and adults to improve adolescent sexual and reproductive health.

METHODOLOGY AND RESULTS: A quasi-experimental study design and quantitative qualitative techniques were utilized in the two study sites and two control sites to test the effectiveness of community participation in defining health needs, service gaps and programmatic approaches. The target group is 700 adolescents, aged 14-24 years, in rural and urban Nepal. During the formative research, we found that although most adults follow traditional norms regarding youth reproductive health issues, their attitudes and ideals about the future of young people are more progressive. Despite current patterns to the contrary, urban and rural adults support later age at marriage, delayed childbearing and the provision of reproductive health information and services to married and unmarried youth. In response, the project team is implementing participatory interventions that involve various community members: parents in workshops that explore youth health concerns and intergenerational communication; service providers in training sessions where they are able to learn about the health needs of married and unmarried youth; and teachers in communicating with youth on reproductive health issues. Such community mobilization activities have created invaluable adult support for youth-centered activities in the community.

CONCLUSIONS: Using a community participation approach yielded unique data that revealed working with parents and key adults is an important strategy for youth reproductive health in Nepal. Community interventions oriented toward adults at multiple stages of the program increase parental and significant adults' knowledge and support for adolescent reproductive health. Further testing is needed to determine if adult involvement leads to longer-term behavior change among youth.

PARTNERS: EngenderHealth, New Era, Bp Memorial Health Foundation

ADDITIONAL AUTHORS: Anju Malhotra, Pushpa L. Moktan

B6
Poison in the Well: Addressing the Arsenic Crisis in Bangladesh

Controlling the Risk Factors of Arsenicosis in a Poor Community: Experience of BRAC in Bangladesh

ABDULLAHEL HADI

LEARNING OBJECTIVES: The participants will be able to understand the magnitude of arsenic problem in Bangladesh that demands a series of systematic studies on various dimensions of this problem. Also, the experience of the arsenic mitigation project of BRAC will help others who are involved in similar kinds of projects.

BACKGROUND: The discovery of hazardous levels of arsenic in drinking water created concern for its potential health effects among the population in the affected communities in Bangladesh. More than 35 million people in the country are at the risk of arsenic poisoning. Among those, it is estimated that nearly 21 million people were exposed to arsenic concentrations above the Bangladeshi standard of 0.05 mg/l. The arsenic poisoning is manifested primarily in skin lesions on the palms of the hands and soles of the feet. The process generally takes 5-15 years to reveal clinical manifestations of arsenicosis. Chronic exposure affects many organs and systems in the body, such as skin, heart vessels, respiratory organs and kidneys, which may lead to the development of lung, kidney and bladder cancer. This study assesses the prevalence and risk factors of arsenic-associated skin lesions and evaluates the arsenic mitigation project of BRAC in Bangladesh.

METHODOLOGY AND RESULTS: Data were collected from a village where BRAC had both health surveillance system and community-based arsenic mitigation project since 1999. A total of 1,654 residents in the study village were examined to detect arsenic-associated lesions on their skin in May 2000. The sociodemographic information was extracted from the surveillance system database covering the village. Nearly 2.9 percent of the study population had clinical manifestations of arsenic poisoning, although the burden of disease was spread unevenly and fell most heavily on certain groups. Multivariate analysis identified age and economic status as significant predictors of arsenicosis controlling for education and gender. The risk of a person to be affected by arsenicosis was high if the person was poor, middle-aged and male. The mitigation project played a significant positive role in raising awareness of the safe water options, signs of arsenic poisoning, mode of transmission and type of treatment.

CONCLUSIONS: The study concludes that the behavioral change aspects of the arsenic mitigation project have the potential to significantly improve the level of understanding about arsenic contamination in the traditional communities.

ABSTRACTS

B6
Poison in the Well: Addressing the Arsenic Crisis in Bangladesh

Drugs and Clean Water Mitigate Arsenic Poisoning in Bangladesh

GOLAM H. RABBANI

LEARNING OBJECTIVES: Participants attending this session will be able to understand the risks to human health of chronic arsenic poisoning and how it could be mitigated using simple technology, such as a water filter drug treatment.

BACKGROUND: Mass contamination of underground water has recently been detected in Bangladesh, exposing 75 million people to the risks of chronic arsenic poisoning. Drinking water from 90 percent of the hand pumps is arsenic-contaminated (normal <50 parts per billion, ppb). Safe drinking water and effective medical treatment are urgently needed to reduce the risks to human health. The objective of this study was to evaluate the effects of drug treatment (antioxidant) and arsenic-free water in reducing arsenic toxicity.

METHODOLOGY AND RESULTS: In rural communities in Bangladesh, 330 adults (men and women) showing clinical signs of arsenic poisoning due to drinking arsenic-contaminated water were enrolled in a double-blind, placebo-controlled trial of a mixture of antioxidants (vitamins and minerals, vms6). Patients were evaluated at their homes by physicians and trained field workers who visited them regularly. Two caplets of vms6 (n=165) or placebo (n=165) were given to patients daily for alternative months for 12 months; effects were assessed by quarterly evaluations of clinical and laboratory parameters. Patients were also supplied with a low-cost, simple, household water filter, locally made with sand, charcoal and iron chips, for purifying arsenic-contaminated water. Concentrations of total and speciated arsenic, including as(iii), as(v), mma, and dma in water, scalp hair, finger nails and urine were measured using atomic absorption spectrophotometer. The vms6 significantly ($P<0.05$) increased the urinary excretion of total arsenic and its metabolites (mma, dma) and reduced arsenic contents of hair and nails. Improvement of skin lesions (keratosis, melanosis), liver functions, renal functions and other clinical manifestations were also observed. Patients given vms6 along with filtered water excreted significantly ($P<0.05$) more arsenic than those given filtered water alone. Water filter consistently removed 95-100 percent of total arsenic in drinking water. Nine months of vms6 treatment specifically reduced 57 percent and 48 percent of total arsenic contents in finger nails and scalp hair, respectively, and doubled its urinary excretion compared to placebo ($P<0.05$). No unpleasant effects were observed. The filter was useful, safe, maintenance free and culturally acceptable.

CONCLUSIONS: Access to arsenic-free water together with antioxidant treatment could be a useful, cost-effective and safe strategy for immediate mitigation of mass arsenic pollution in Bangladesh. The dose and duration of treatment needs to be optimized.

PARTNER: Bangladesh Arsenic Control Society

ADDITIONAL AUTHORS: Keramat Ali, Afzal Hossain, H.K. Das, S.K. Saha, M. Naisr, M. Alauddin, Ak Azad Chowdhury

B5
Community Participation for Youth Reproductive and Sexual Health

Mobilizing Communities: Youth to Youth for Healthy Life

AMY WEISSMAN

LEARNING OBJECTIVES: Participants attending this session will be able to recognize the effectiveness of community mobilization for improving youth reproductive and sexual health.

BACKGROUND: Young people often lack power and influence in their communities, families and relationships; thus, ensuring that they have information and skills is often not enough to affect reproductive and sexual health outcomes. Creating an enabling environment in which key adults (parents, teachers, religious leaders and service providers) support and facilitate young people's access to reproductive and sexual health information and services and their adoption of healthy practices is key. In Mangochi district, Malawi, Save the Children recognized the importance of addressing community norms to affect health outcomes among youth and used community mobilization to do so. Following participatory data collection, workshops among youth, government officials, religious leaders and other key adults were held to share the findings, identify priority issues (sexual exploitation, harmful traditional practices and inadequate reproductive health services for youth) and to design program strategies. Two key strategies used were positive deviance and youth-defined quality. The first addressed messages and practices promoted during traditional initiation ceremonies, while the second engaged young people and service providers in a process of improving the quality, accessibility and availability of care. In these strategies and throughout, young people in partnership with key adults have been central to the management, implementation, monitoring and evaluation of the project.

CONCLUSIONS: Using a community mobilization approach was effective at both creating an enabling environment (significantly more youth in the project than in control sites reported talking with parents about a romantic/sexual relationship) and at affecting young people's knowledge and behaviors (male youth demonstrated significant increases in condom use and in knowledge about sexually transmitted infections/HIV/AIDS as compared to the baseline). Community mobilization also enhanced community ownership of the project and ensured cultural relevance and sustainability. However, when using community mobilization, it is important to ensure youth – or any less powerful group within a community – are able to participate equally as others.

PARTNERS: Community, religious and government organizations

ADDITIONAL AUTHOR: Mary Kumwenda

ABSTRACTS

B6
Poison in the Well: Addressing the Arsenic Crisis in Bangladesh

Combating the Health Effects of Arsenic Exposure from Drinking Water in Bangladesh: Experience from the Columbia University Arsenic Project

HABIBUL AHSAN

LEARNING OBJECTIVES: Participants will understand the health effects of exposure to arsenic in drinking water and identify appropriate measures for tackling this massive public health problem.

BACKGROUND: Bangladesh is currently facing one of the largest mass poisoning events in history from the arsenic contamination of drinking water. It is estimated that between 30 and 70 million people had been drinking water with high arsenic levels for many years and thus are at risk of developing arsenic-induced cancers and other life-threatening diseases. To understand and develop appropriate measures for tackling this massive public health problem, Columbia University researchers, in collaboration with Bangladesh scientists, initiated a comprehensive project in 1999 in a well-defined geographical area of Bangladesh targeting approximately 70,000 residents.

METHODOLOGY: In order to assess the magnitude of the problem and to set a stage for an in-depth prospective epidemiological cohort study to examine the effects and remedies of both the short- and long-term adverse health effects of arsenic, all 6,000 hand-pumped wells in the study area were tested, and population survey data were collected from well-users. As part of the health promotion/mitigation components of the project, the following measures were undertaken and their effectiveness is being evaluated. First, information on arsenic concentrations of the tube-wells, its health implications and remedies (including sources of alternative arsenic-free drinking water from the nearest safe well as a short-term option) was disseminated in a systematic manner to the residents of the study area. Second, for the most heavily contaminated areas deep tube-wells (yielding arsenic-free water) were installed based on an algorithm derived from the geographic information system (GIS) data, water arsenic concentration, distance of a nearby safe well and population density of a given neighborhood to maximize the utilization of the wells. Third, a field clinic, dedicated for the study population, was established to provide primary health care to arsenic-affected individuals for their treatment and clinical follow up. Finally, a detailed disease history and health and drug utilization data are also collected and analyzed on a regular basis to develop a patient profile and to evaluate effective treatment protocol for future use. As part of the evaluation of our health promotion/mitigation efforts, follow-up surveys and measurements are being conducted to quantify the changes in the knowledge of health risks and health behavior (measured by rate of changes in knowledge of health risks and adoption of healthy behavior), arsenic exposure burden (measured by urinary arsenic) and health effects of arsenic (measured by prevalence of arsenicosis).

CONCLUSIONS: Preliminary results of these health promotion efforts and interventions as well as some initial findings from the ongoing in-depth prospective cohort study will be presented at the meeting. We believe that lessons learned from this comprehensive project may be useful in tackling the massive problem of arsenic at a national level.

ADDITIONAL AUTHORS: Faruque Parvez, Iftikhar Hussain, Hassina Momotaj, Lex van Geen, Joseph H. Graziano

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B7
The Unhealthy Hearth: Indoor Air Pollution from Cooking and Heating Fuels

Testing Behaviors to Reduce Indoor Air Pollution Impacts

BRENDON BARNES

LEARNING OBJECTIVES: By the end of the presentation, participants will understand how behavior change is feasible and offers the possibility of a cheap method to reduce the impact of indoor air pollution on child health.

BACKGROUND: The role of behavior change to reduce the impact of indoor air pollution has been neglected by research in the field. In response to this, a pilot study has been underway in South Africa to test the feasibility of four behaviors at the household level before the implementation of the main intervention. The behaviors, identified in a previous phase of research, are to improve stove maintenance practices, open ventilation for longer periods of time during burning, reduce the amount of time that children are in the room during burning, and reduce the length of time that solid fuels are burned.

METHODOLOGY AND RESULTS: The study employed a Trials of Improved Practices methodology to test the behaviors. Thirty-two households participated in the study. Behaviors were assessed in each household at the beginning of winter 2002. Based on this, household visits were arranged in which educators delivered the key health messages and negotiated with household members which behaviors they would perform. Behaviors were re-assessed one month later. Results show a relatively low compliance rate for stove maintenance behaviors (10 percent) but a higher compliance rate for opening ventilation for longer periods of time (67 percent), reducing the amount of time that children are in the burning room during burning (53 percent) and reducing the length of solid fuel burning (43 percent). The intervention reduced the amount of time that children were present in the room while a fire was burning, increased the length of time that two sources of ventilation were opened, and reduced the length of solid fuel burning. The results of each behavioral cluster as well as the barriers to the performance of the behaviors will be discussed.

CONCLUSIONS: It is concluded that all four behaviors are feasible in this context and behavior change may offer a cheap yet effective strategy to reduce the impact of indoor air pollution on child health.

PARTNERS: The CHANGE project, Manoff Group, USAID

ADDITIONAL AUTHOR: Angela Mathee

B7
The Unhealthy Hearth: Indoor Air Pollution from Cooking and Heating Fuels

Health Benefits of Household Energy Transitions in Kenya

MAJID EZZATI

LEARNING OBJECTIVES: Based on examples from three different countries, participants attending this session will gain a sense of the magnitude of exposures to indoor air pollution associated with cooking and heating with solid fuels, and the effectiveness of interventions for exposure reduction.

BACKGROUND: Acute respiratory diseases, which are causally linked to exposure to indoor air pollution in developing countries, are one of the leading causes of childhood morbidity and mortality in developing countries. Improved (high-efficiency and low-emission) stoves offer the potential for exposure reduction.

METHODOLOGY AND RESULTS: We use continuous monitoring of indoor air pollution and individual time-activity budget data to construct detailed profiles of exposure for 345 (including approximately 100 children under the age of five years) individuals in 55 households in rural Kenya. We then compare the reductions in personal exposure and disease as a result of changes in stove technology or fuel. Data for analysis are from 210, 14-hour days of continuous real-time monitoring of particulate matter concentration under the conditions of actual use as well as the location and activities of household members, supplemented by data on spatial dispersion of pollution and interviews. Longitudinal data on acute respiratory infection (ARI) and acute lower respiratory infection (ALRI) were recorded in weekly clinical examinations. We estimate that the range of interventions considered here, on average, reduce the fraction of times that infants and children below five are diagnosed with disease by 24-64 percent for ARI and 21-44 percent for ALRI.

CONCLUSIONS: These reductions due to environmental management in infant and child ALRI are of similar magnitude to those achieved by more costly medical interventions.

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B7
The Unhealthy Hearth: Indoor Air Pollution from Cooking and Heating Fuels

Predicting Indoor Air Pollution in Rural Indian Households

SUMI MEHTA

LEARNING OBJECTIVES: Based on examples from three different countries, participants attending this session will gain a sense of the magnitude of exposures to indoor air pollution associated with cooking and heating with solid fuels, and the effectiveness of interventions for exposure reduction.

BACKGROUND: Cooking and heating with solid fuels, such as dung, wood, agricultural residues, charcoal and coal, is likely to be the largest indoor source of air pollution exposure in developing countries. Combustion of solid fuels in inefficient stoves under poor ventilation conditions can result in large exposure burdens, and is associated with many health effects, particularly in women and young children. Countries such as India, where solid fuels remain the primary household energy source for a majority of the population, need low-cost exposure assessment methods to identify households likely to have the highest exposures.

METHODOLOGY AND RESULTS: A survey was administered in approximately 420 households in three districts of Andhra Pradesh to collect information on housing and kitchen types, ventilation and other factors related to indoor air pollution. Using respirable particulate matter as an indicator pollutant, each household was monitored for daily average concentrations of indoor air pollution in the kitchen and living areas. Models to predict quantitative categories of exposure based on housing and fuel characteristics were developed. Three variables are significantly associated with high kitchen concentrations: fuel type, kitchen type and kitchen ventilation. Fuel type is the single most important predictor of high household concentrations. Used alone, however, it results in a great deal of misclassification of low-concentration households. Adding information on either kitchen type or kitchen ventilation (observer assessed) improves misclassification substantially. Households with indoor kitchens are more likely to have high concentrations, as are households with poor kitchen ventilation.

CONCLUSIONS: Targeting ventilation can reduce exposure within solid fuel-using households substantially. This suggests that, just as access to clean water and sanitation are used as indicators of water pollution, access to clean fuel and access to ventilation can be used to indicate the potential for high exposures to indoor air pollution. There should continue to be an emphasis on reducing exposures within solid fuel-using households via improved stoves or other locally appropriate means, until everyone can be given access to cleaner fuels.

PARTNERS: Sri Ramachandra Medical College and Research Institute, Institute of Health Systems

ABSTRACTS

C2
Tools for Prevention: Communication Strategies to Fight HIV/AIDS

Goal-Directed HIV/AIDS Prevention Strategies: Journey of Hope

EMMANUEL D.K. FIAGBEY

LEARNING OBJECTIVES: Participants will be able to: recognize the need for adopting psychosocial strategies in promoting prevention and management of HIV/AIDS; and identify the key features of the Journey of Hope HIV/AIDS communication tools for adoption in their own programs.

BACKGROUND: As HIV infections and AIDS-related deaths continue to rise, HIV/AIDS educators are faced with the challenge of developing and using the most effective strategies for promoting behavior change among various populations with the hope of slowing down its devastating impact. The Journey of Hope package of tools responds to this challenge by assisting organizations, individuals, schools and community groups in Ghana to more effectively adopt participatory and goal-directed approaches in communicating messages on prevention and management of HIV/AIDS. Journey of Hope employs psychosocial principles based on self-concept, experience, readiness, orientation and motivation to help young people develop life skills for making positive life choices in avoiding HIV and managing its infection. The Journey of Hope tool kit is comprised of the following: 1) Narrow Bridges, which introduces HIV prevention and enables participants to visually, physically and symbolically experience the three ways of avoiding HIV/AIDS – abstinence, faithfulness and/or condom use; 2) Fleet of Hope, which enables participants to discuss in-depth the HIV prevention measures and examine their own personal choices;
3) Future Islands, which motivates people to envision a future – a goal that they must strive for and feel happy in achieving by avoiding HIV infection or managing it positively; and 4) Trigger Sketches, which provides situational studies in a dramatic way for dealing with practical issues on the way to each individual's attainment of one's life goals.

CONCLUSIONS: Journey of Hope has been applied in communities throughout Ghana, Kenya, Sierra Leone, Gambia, Zambia, Scotland and Germany. The key lessons learned are: 1) Using participatory storytelling with interactive visuals and symbols in fun and interesting ways promotes open discussion about sexual behavior and HIV/AIDS.
2) These tools clarify choices and build skills that empower people to protect themselves from HIV infection. 3) Goal-directed education and communication tools encourage people, including people living with HIV/AIDS, not to give up on life but to plot their own course to safer lifestyles, linked to achieving outcomes that they really want and value in life. Journey of Hope helps people change their behavior by keeping them focused on life goals and the most positive behavior required for achieving these goals. It is applicable as young people in all communities would always be fascinated to envision a future that presents opportunities for happy growth and development and would feel encouraged to protect that future. It is therefore recommended that participatory and goal-directed strategies adapted to the physical, social and psychological environment in which people live should be employed in promoting HIV/AIDS education at both individual and community levels.

PARTNERS: Johns Hopkins University Center for Communication Programs, Potential Unlimited UK, USAID, UNAIDS

C2
Tools for Prevention: Communication Strategies to Fight HIV/AIDS

The Performing Arts in HIV/AIDS Prevention in Africa: How to Help Preserve a Fragile Social Ecosystem Through Storytelling Theater

LOUISE LINDENMEYR

LEARNING OBJECTIVES: Participants attending this session will be able to: recognize the value of using drama, masks, music, play writing and songwriting in promoting public health messages; understand a technique that promotes the sharing of performing traditions of both cultures, which strengthens its impact at the grassroots; inspire the participant to consider the use of these tools in the promotion of his/her own program.

BACKGROUND: Established in 1978, Project Troubador (PT) works to bridge cultural, racial and ethnic gaps by modernizing the ancient concept of the troubadour. By sending musicians, dancers and mimes to developing areas of the world, we enhance the efforts of grassroots organizations working for social change, person to person, through our street theater style performances. HIV/AIDS has had an enormous impact on the social ecosystem of Africa. Professionals and mobile, affluent members of African society were the first to succumb to the disease, but now it has permeated every level of society. From dirt farmers to schoolteachers, AIDS has upset the fragile social balance. Statistics in Cameroon now show that four out of every ten young men entering the military last year tested positive for HIV. In developing countries, the challenge of educating the public is compounded by lack of funds, facilities and basic skills such as reading and writing, as well as cultural traditions that bind society and resist change. The performing arts can help people think and talk about sensitive or controversial issues more easily. Music and drama enable them to look at their lives in new ways and to privately discover behaviors that may need change, without feeling publicly embarrassed or threatened. Through songs, dance, humor and short theatrical pieces, PT has joined forces with approximately one dozen grassroots AIDS organizations in three countries, encouraging men and women to take personal responsibility in the struggle against AIDS. After all performances, question-and-answer sessions, and condom and pamphlet distribution are carried out by local educators. Working closely with Kongadzem, a local women's self-help organization of the Nso people of northwestern Cameroon, PT has staged tours there in 1997 and 1999. In 2001 and 2002, we strengthened our collaboration by preparing Kongadzem to carry on this style of education after our departure. After 10 days of performing for secondary school children and villagers, we held workshops in playwriting, acting and songwriting.

CONCLUSIONS: The performing arts can provide an exciting, non-threatening and easily accessible means of affecting behavior change in HIV/AIDS prevention. By using a theatrical form of personal storytelling, we can inspire a creative community response to the sensitive issues surrounding HIV/AIDS. Grassroots NGOs may increase their visibility and status with local populations by providing entertaining and informative presentations that do not 'preach' and do not require literacy. This U.S. organization's fostering and development of a long-term collaboration with a local African NGO has strengthened each party's impact - it can respond better to changing needs and problems as well as the talents, traditional beliefs and interests of the local population.

PARTNERS: Kongadzem - Nso Women's Social And Development Association, Bamenda Branch, Cameroon

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C2
Tools for Prevention: Communication Strategies to Fight HIV/AIDS

Youth Leaders: Making a Change in the Epidemic

PAKO SELEMOGO

LEARNING OBJECTIVES: By the end of the presentation, participants will be able to identify strategies for youth and youth activists to organize, network with other youth activists and effect change in their communities around HIV/AIDS.

BACKGROUND: Often, people who work with youth do not see them as advocates and think they lack the training or funding to engage in advocacy. However, the best programs meaningfully involve youth in advocating for, designing, implementing and evaluating prevention strategies. In fact, youth are often articulate and compelling advocates for better programs and policies. Young people engaged as valued partners in HIV/AIDS prevention often become their own best spokespeople, educating policy-makers, parents, service providers and each other about effective youth-oriented HIV prevention. In Nigeria and Botswana, where new HIV/AIDS infections are disproportionately occurring in youth, young people are coming together to fight the epidemic. Partnering with Advocates for Youth, two youth-led organizations, the Nigeria Youth Action Rangers and the Youth Health Organization of Botswana have been implementing youth-oriented HIV/AIDS prevention programs and policies. As a result of building the capacity with and for these youth-led groups, youth are expanding their skills as educators and advocates by promoting youth-friendly sexual health services, networking at conferences, building an online community of youth activists, creating visibility campaigns and advocating for program and policy work to increase youth participation.

CONCLUSIONS: Through a comprehensive youth-led initiative, both NYAR and YOHO are implementing successful, far-reaching, well-received and comprehensive programs to prevent the spread of HIV/AIDS among young people. Through their work, both have experienced increased numbers of youth mobilized for HIV/AIDS prevention and education activities, increased numbers of youth participating in programs and working on national-, state- and local-level policy on these issues, and increases in their own skills and abilities around leadership and advocacy.

PARTNERS: The Nigerian Youth Action Rangers, the Youth Health Organization of Botswana

ADDITIONAL AUTHORS: Sydney West, Moses Imayi, Mayowa Joel, Edwin Mathalidisa, Faith Oteng

C3
Life in Balance: Partnering to Improve Reproductive Health and the Environment

Creating Synergy in Integrated Population Health and Environment Programs

NAIDA G. PASION

LEARNING OBJECTIVES: Participants will be able to: identify elements that contribute to the success of an integrated population, health and environment program; and draw out lessons learned in community-managed programs linking population, health and environment.

BACKGROUND: As the acronym for People and Environment Co-Existence Development Project, PESCO-Dev is derived from the Spanish word 'pescar,' meaning fish, a fitting way to express the project's main concern of ensuring a harmonious balance between coastal resources and population growth. PESCO-Dev aims to provide choices for couples of reproductive age to have children at the time that they want to, while improving their capacity to ensure a healthy and secure environment for their children. The project is based on the premise that more couples who have unmet needs will translate these needs into contraceptive actions once they know that these actions will result in better environmental quality and livelihood sustainability. Conversely, knowing that the conservation and rehabilitation of coastal resources will positively affect the health and well-being of the population, there is greater impetus for people to pursue environmental goals. The pilot project was implemented in four coastal municipalities of the Western Visayas region, covering a total population of 18,569. The contraceptive prevalence rate of 38 percent increased by 5 percent in only six months of implementing couples family planning sessions that integrate population and environment discussions. Moreover, male community members exhibited higher rates of participation in the sessions once they found out that population pressure was linked to environmental resources and thus livelihood.

CONCLUSIONS: Facilitating factors toward achievement of project goals include increasing interest and support among local government units in linking population and environment. By themselves, family planning and coastal resource management have not generated as much support from the local government units and the community members as when the two concerns were linked. Targeting small fisherfolk, one of the most affected groups by coastal environment degradation, and focusing on those who have unmet needs for family planning in this group, increase positive project impact. Forging strategic partnerships increased project capacity. Using a strategy called appreciative community mobilization that builds on the existing assets and capacity of the people helped to ensure organizational, technical, financial and community sustainability. Hindering factors include: 1) the negative attitude of public health service providers toward providing counseling and contraceptive support for unmarried adolescents and low valuation of the need to provide quality reproductive health services; 2) lack of experience, as population and environment is a pioneering effort in the Philippines; 3) the unique cultural and religious context of family planning work; and 4) lack of serious and honest commitment among local government officials in population and environment.

PARTNERS: Local government units of Concepcion, Ajuy, Sibunag and Jordan; national government agencies; fisherfolk organizations; local academic and technical organizations

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C3
Life in Balance: Partnering to Improve Reproductive Health and the Environment

Healthy Communities and Healthy Environment in Madagascar

BARTHELEMY RAKOTOTIANA

LEARNING OBJECTIVES: The participants will understand the advantages of the integrated health-environment approach at the organizational and community level as well as strategies used for expansion.

BACKGROUND: In the Moramanga region, deforestation of the forest corridor Ankeniheny-Zahamana is leading to loss of endemic biodiversity, such as lemurs, orchids and amphibians. Destruction of the forest also causes water sources to run dry and become polluted, which leads to higher rates of diarrheal disease and malaria that are exacerbated by the high rate (48 percent) of child malnutrition. Baseline data from these regions show that knowledge in the communities is high regarding the rational management of natural resources and good health practices. It is the role of SAF (a Malagasy NGO) to facilitate the community's access to basic services and to help them adopt best practices. SAF, through the implementation of the health-environment project, has helped communities to improve the management, communication and coordination of their own activities and at the same time has ensured a good coordination between the development players from different sectors.

CONCLUSIONS: After two years of implementing projects in 18 'integration' villages in three communes serving 10,000 beneficiaries, there have been many good results. The existence of community structures facilitated the installation of several community-based health services, such as vaccinations, child growth monitoring, essential medicines, family planning and the practice of new agricultural techniques to increase production, relieve pressure on natural resources and increase household income. Between 2001 and 2002, the vaccination coverage rate increased from 42 percent to 49 percent, regular users of modern family planning increased from 5 to 27 each month, and there were 21 new users during this period. In addition, child malnutrition decreased from 24 percent to 18 percent between January and August of 2002. These improvements result from the work of the community volunteers and the close collaboration between development programs in the region. Operational research showed that communities are changing their attitude and their behaviors due to these interventions. SAF is able to expand this approach into neighboring communities at a faster rate because model farmers are teaching their peers and there is less need for technicians from development projects.

PARTNERS: USAID/EHP, Tany Meva, Packard and Summit Foundations, government agencies

C3
Life in Balance: Partnering to Improve Reproductive Health and the Environment

Impacts of Integrated Reproductive Health and Agriculture Program in North Potosi, Bolivia

ERIKA C. VOHMAN

LEARNING OBJECTIVES: Participants will be able to evaluate impacts of integrated agriculture and reproductive health programs on adoption of health, family planning and agricultural practices in rural indigenous Andean communities in Bolivia. Other impacts will be identified in areas of gender equity, leadership, agricultural production and well-being.

BACKGROUND: The integrated program (IP) is a holistic approach to community development offering reproductive health (RH) and sustainable agriculture (SA) education and services in a comprehensive package. Program objectives include improvements in food security, capacity for leadership, organization, communication and agricultural experimentation as well as ensuring access to reproductive health and agriculture supplies and services. All IP staff are cross-trained in RH and SA, including doctors, nurses, agronomists and all field and office personnel. The program works with the government ministries of health and education to maximize resource efficiency and ensure the long-term sustainability of the program. The primary research goal was to better understand the mechanisms of the IP that increase community acceptance of RH and SA practices. Several hypotheses were investigated, including: 1) the IP contributes to improvements in economic income and quality of life; 2) adoption of improved practices in agriculture influences adoption of family planning; 3) improved communication between spouses increases women's status in the family and individual self-esteem; and 4) exposure to development organizations enhances adoption of practices in health and agriculture.

METHODOLOGY AND RESULTS: This study incorporated surveys, focus groups, participatory exercises and semi-structured interviews to determine IP impacts. Communities exposed to the IP reported increases in economic income, well-being and agricultural production. Family planning increased from near zero percent to 42 percent as a result of the IP over a five-year period. There were improvements in communication between spouses, women's participation in agriculture and leadership in the IP communities.

CONCLUSIONS: This study helped reveal indicators useful in examining linkages between the different sectoral activities implemented in the integrated program. Later phases of research will seek to clarify these linkages and their application to the field of population and environment.

PARTNERS: Ministries of Health and Education

ADDITIONAL AUTHORS: Humberto Beingolea, Moises Perez

ABSTRACTS

C4
Strengthening Provider Skills for Child and Reproductive Health

Integrating Youth-Friendly Approaches into Pre-service Nursing Internships

CYNTHIA EYAKUZE-DI DOMENICO

LEARNING OBJECTIVES: Participants will be able to cite three advantages of integrating youth-friendly approaches into the pre-service education and clinical internships of public sector health workers.

BACKGROUND: African governments and NGOs are struggling to find the most effective, cost-effective and sustainable approaches for reaching adolescents with needed health information and services. Stand-alone youth centers have proven costly, school-based programs reach only those in schools, peer education may not improve access to services, and private sector- or NGO-based initiatives have limited reach. Integrating adolescent sexual and reproductive health (ASRH) knowledge, skills and youth-friendly approaches into the pre-service education and clinical internships of public sector health workers offers the advantages of integration, cost-effectiveness, broad reach and longer-term sustainability.

METHODOLOGY AND RESULTS: A major effort was undertaken by the National Public Health School of Burkina Faso to integrate ASRH knowledge and skills and youth-friendly approaches into the pre-service education and internship training provided to all future nurses, midwives and community health agents in Burkina Faso. Through this initiative, the school's adolescent reproductive health curriculum was expanded and strengthened, and youth-friendly services were integrated into six Ministry of Health health centers that serve as clinical internship sites. Newly graduated health workers thus obtain practical, hands-on experience observing and providing services to youth. Key steps included: 1) initial workshops to discuss the initiative with health providers, parents and community leaders; 2) training courses on ASRH issues for providers in the six health centers; 3) workshops in each health center to develop specific plans and timetables for integrating youth-friendly services; 4) development of training materials and provision of ongoing technical support by Family Care International; 5) establishment of new services and implementation of linked educational and outreach activities; 6) supervisory visits to the sites to support and assist them throughout the process; and 7) final evaluation.

CONCLUSIONS: Integrating ASRH knowledge, skills and youth-friendly approaches into pre-service education and internships for health workers offers the advantages of integration, cost-effectiveness, broad reach and sustainability.

PARTNERS: National Public Health School, Burkina Faso Ministry of Health, Association Burkinabè pour le bien-être familial, Family Care International

ADDITIONAL AUTHORS: Djénéba Diallo, Justin Poda, Pamela Bolton

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C4
Strengthening Provider Skills for Child and Reproductive Health

Skilled Providers, More Clients: Implementing an Essential Service Package in Bangladesh

SHALINI SHAH

LEARNING OBJECTIVES: By the end of this presentation, participants will be able to describe the Government of Bangladesh's Essential Service Package (ESP) and assess results from the PRIME II Project's assistance to the USAID National Integrated Population and Health Program in implementing the ESP for private-sector paramedics and doctors.

BACKGROUND: The PRIME Project began collaborating with NIPHP in 1998 to build capacity for implementation of the ESP at private-sector primary health-care facilities staffed by paramedics and doctors. Through a government program, PRIME is also helping implement the ESP through a national in-service training program for public sector providers. The combined public-private sector effort is geared to ensure that the ESP meets the needs of communities in every part of Bangladesh. Focusing in the areas of maternal health and sexually transmitted infections (STIs)/reproductive track infections (RTIs), child survival interventions and family planning services, PRIME II has systematically helped to develop training materials and curricula, improve the skills of trainers, and significantly strengthen the capacity of nine in-service training organizations.

METHODOLOGY AND RESULTS: The final report on PRIME II's assistance to NIPHP demonstrates that the technical knowledge and skills of providers who benefited from PRIME's comprehensive training strategy are significantly better than those of untrained counterparts at service delivery sites. The study found that all 959 paramedics trained in maternal health and STIs/RTIs were performing to standard and 81 percent of paramedics trained in child survival interventions were performing to standard. A comparison of trained and untrained paramedics revealed that 96 percent of the trained providers had adequate knowledge in maternal health and STIs/RTIs as opposed to 62 percent of untrained; trained paramedics outscored their untrained counterparts 64 percent to 24 percent in knowledge of child survival interventions. The study also showed that utilization of clinic services increased dramatically in facilities with trained paramedics.

CONCLUSIONS: Strengthening training organizations to implement the ESP has resulted in improved levels of provider performance in an expanded array of reproductive health and child survival services. In turn, the accessibility and quality of these services has increased for many thousands of Bangladeshis. The program holds great promise for national replication.

PARTNER: Government of Bangladesh

ADDITIONAL AUTHOR: James McMahan

C4
Strengthening Provider Skills for Child and Reproductive Health

Improving Provider Performance in Child Health Services

AMY SHIRE

LEARNING OBJECTIVES: Participants attending this session will be able to describe COPE (client-oriented, provider-efficient services) for child health and to articulate outcomes on provider performance, client satisfaction and client knowledge.

BACKGROUND: COPE is a process and set of tools for all levels of health-care staff and supervisors to improve services. In 1999, EngenderHealth and its partners adapted the COPE tools for child health services to support the Integrated Management of Childhood Illness (IMCI) approach. Earlier COPE studies had shown increased provider motivation, problems solved and reduced client waiting time. This is the first study to show significant differences in provider performance, client satisfaction and caregiver knowledge between intervention and control sites.

METHODOLOGY AND RESULTS: Baseline and final evaluations (at 15 months) were conducted in eight intervention and eight matched 'control' (non-intervention) sites in Guinea and Kenya. Each intervention site conducted 4-5 COPE exercises. Assessments included 157 provider interviews, 16 facility audits, 360 client exit interviews, 360 observations of client/provider interactions for both sick and healthy children, and eight focus groups with 88 (intervention site only) staff. All quantitative data were analyzed in SPSS to examine differences between intervention and control sites. Intervention site staff performed significantly better than control site staff on 39 out of 45 indicators ($P<0.05$). Changes include more respect for clients, more information and greater privacy given to clients, better communication skills, diagnostic skills, home care instructions, prescribing practices and immunization practices. Intervention site clients expressed significantly higher levels of satisfaction and health-care knowledge on 22 out of 23 indicators ($P<0.01$).

CONCLUSIONS: COPE was associated with dramatically improved provider performance, higher client satisfaction and higher client/caregiver knowledge. The low-tech, low-cost process encouraged staff to decide for themselves how to improve health services. Although the COPE guides suggest standards of care, there was no specific intervention or training associated with them (e.g., no specific training in IMCI in either country). Limited additional investments in intervention sites included some equipment and limited training in areas identified by staff themselves, primarily infection prevention, IEC (information, education, communication) and immunization. Most improvements in intervention sites came only from staff.

PARTNERS: UNICEF, Africa Bureau of USAID, USAID REDSO/ESA, BASICS, Academy for Educational Development

ADDITIONAL AUTHORS: Jan Bradley, Susan Igras

C5
Mainstreaming Prevention of Diarrhea in Child Health

The Sanru Experience: Integrating Hygiene Improvement into Primary Health Care

PAULIN KALONJI

LEARNING OBJECTIVES: Participants attending this session will learn how hygiene improvements, behavior change communications and community-based Integrated Management of Childhood Illnesses (C-IMCI) are being integrated into the decentralized primary health care system of the Democratic Republic of Congo.

BACKGROUND: The Sanru Basic Rural Health Project I/II (1981-1991) found that water and sanitation could (and should) be an important entry point for developing a decentralized primary health care system. In collaboration with the Ministry of Health, Sanru trained and supported nearly 100 water and sanitation coordinators for DR Congo's 306 decentralized health zones. The Sanru III project (2001-2006) is faced with the challenge of revitalizing and expanding the network of water and sanitation coordinators, and increasing the program emphasis on and support for hygiene improvements, behavior change communications and C-IMCI.

CONCLUSIONS: The Sanru project, with technical assistance from the Environmental Health Project II, has identified and is currently implementing the following strategies: 1) conduct formative research to identify key high-risk hygiene behaviors and develop a behavior change strategy that addresses the identified behaviors; 2) encourage operations research by health zones to identify existing, motivated community structures and individuals to serve as 'community relays' for C-IMCI and hygiene improvements; 3) develop in-service training materials and a program for health center nurses to train 'community relays' and water/sanitation coordinators to provide C-IMCI and hygiene improvement messages, and to support the work of community relays; 4) develop and provide appropriate project support from Sanru, BASICS and other national programs for the C-IMCI and hygiene improvement activities; and 5) conduct these activities in collaboration with the Ministry of Health's hygiene direction in order to institutionalize and replicate these approaches in all health zones, including those supported by other donors. The current situation of water supply, sanitation and hygiene behaviors will be illustrated using findings from the baseline household survey conducted earlier in 2002. The presentation will also describe how these data were used to design and implement hygiene improvement interventions at the community level involving health facilities and community groups.

PARTNERS: Ministry of Health, UNIKIN School of Public Health, BASICS, USAID

ADDITIONAL AUTHORS: Franklin C. Baer, Felix Minuku

ABSTRACTS

C5
Mainstreaming Prevention of Diarrhea in Child Health

Combining Hygiene with Hardware for Maximum Impact in the Dominican Republic

ROBERT KOLESAR

LEARNING OBJECTIVES: Participants attending this session will be able to understand the benefits of integrated, community-based hygiene, water and sanitation interventions. Additionally, they will understand stakeholder concerns, opportunities for collaboration and the role of participatory community monitoring.

BACKGROUND: A comprehensive, participative approach is often not understood or valued by all partners, thereby often making it a non-starter. Education and advocacy can be effective tools to mobilize all stakeholders. Nine NGOs involved in water and sanitation system reconstruction and the Ministry of Health were key to designing and implementing a strategy for community-level behavior change, with the goal of preventing diarrheal disease. Visually attractive educational materials were developed, tested and are now promoted nationally.

CONCLUSIONS: Participatory community monitoring was built into the hygiene behavior-centered programming process. Hygiene promoters did an initial assessment in December 2001 in a sample of 109 households, followed by five months of intensive hygiene promotion in the target communities. The promoters monitored changes in key behaviors in May 2002 in a sample of 126 households. Results were very positive in terms of skill development of the NGO coordinators and health promoters in the community, as well as demonstrated behavior change at the household level. For example, the proportion of households with a permanent place for handwashing doubled; and the percent of caretakers who washed their hands after defecation rose by 27 percent. The project worked successfully as a multisectoral team of participating agencies, including INAPA, SESPAS, PAHO and NGOs. In follow-up interviews, partners highlighted their commitment to utilizing the materials and methods in their ongoing work. The coordinated mobilization of many and varied stakeholders involved in primary health care, water and sanitation is challenging. Collective efforts often require institutions and individuals to think and work in new ways. However, the benefits of such efforts seem to outweigh the costs. It is anticipated that this behavior change model will ultimately be incorporated into community-based Integrated Management of Childhood Illnesses (C-IMCI) in the Dominican Republic.

PARTNERS: Environmental Health Project, USAID, local NGOs, Catholic Relief Services, Ministry of Health, PAHO, Peace Corps, National Water Authority, communities

ADDITIONAL AUTHORS: Marco Polo Torres, Candida Gil, Victoria Cruz, Eckhard Kleinau

C5
Mainstreaming Prevention of Diarrhea in Child Health

Trends In Diarrhea Morbidity: Why Prevention Is Important

CLAUDIO F. LANATA

LEARNING OBJECTIVES: Participants attending this session will be able to understand the current trends on diarrhea morbidity and mortality in less-developed countries and why there is a need to expand previous diarrhea control measures that were focused only on case management to now include diarrhea prevention activities, particularly in the areas of hygiene and hygienic stool disposal practices.

BACKGROUND: Diarrhea control measures have been implemented in most developing countries since 1980, mostly focused on promotion of the oral rehydration solution as well as increasing water and sanitation programs. In a review of recently published literature, it has been found that while diarrhea mortality has been reduced in this period of time, diarrhea morbidity has not, despite the improvements on access to water and sanitation and increased immunization coverage.

CONCLUSIONS: It is important to expand the content of diarrhea control programs to focus on diarrhea prevention strategies, such as the promotion of hand washing and sanitary disposal of feces in the household environment. In the review of promising interventions in these areas, it has been seen that handwashing with soap (or other similar agents) is an effective intervention to reduce diarrhea morbidity and should be further promoted. The use of potties and effective practices removing human feces from the household environment are also important interventions that require further evaluation.

PARTNERS: Department of International Health, Johns Hopkins University School of Public Health, London School of Hygiene and Tropical Medicine

ADDITIONAL AUTHORS: Walter Mendoza, Ana I. Gil, Beth Yeager, Robert E. Black, Sharon Huttly

C6
Environmental Issues in Income Generation and Health

Increasing Rural Nepalese Incomes and Nutritional Status

LARRY MORGAN

LEARNING OBJECTIVES: Participants will learn the key elements of a successful rural development project that incorporated food-based vitamin A promotion in a high-value crop development program to sharply reduce night blindness among pregnant and lactating women.

BACKGROUND: Over 80 percent of Nepal's people rely on farming for their livelihood, but low-value crops such as rice and maize dominate agricultural output and diets are highly deficient in necessary vitamins and minerals. Rural pregnant and lactating women are particularly vulnerable to night blindness due to low vitamin A intake. Although Nepal has the potential to produce large quantities of high-value and nutritious commodities, it imports most of these from neighboring India, but at prices still outside of the means of the rural poor. Under a USAID contract, Chemonics International implemented the Market Access for Rural Development (MARD) project to expand the market for high-value commodities and improve household nutrition status. MARD focused on promoting market growth, improving technology and agricultural extension services, building capacity for agricultural planning and policy reform, and enhancing household diets to combat the high incidence of night blindness among pregnant women.

CONCLUSIONS: MARD helped over 40,000 Nepali farm families increase sales of high-value agricultural products by over 300 percent, without significantly depressing farm prices. A practical food-based nutrition program was combined with expanded commercial high-value crop production to reduce the incidence of night blindness among pregnant or lactating women in project areas by 50 percent. These results were achieved by introducing hundreds of farmers to new production methods and improved crop varieties through more than 1,400 on-farm crop demonstrations, and marketing and technology training sessions for over 15,000 participants. Over 20 household nutrition demonstration sites were dispersed throughout the crop demonstration areas to introduce nutritional information and household kitchen gardening techniques, and to support onsite training sessions for over 11,000 female participants. These high-value crop development and food-based vitamin A improvement programs were incorporated in the extension training programs of the Nepal Ministries of Health and Food and Agriculture.

PARTNERS: Chemonics International, METCON Consultants, No-Frills Consulting Co., Nepali Technical Assistance Group, University of California-Davis, Volunteers in Overseas Cooperative Assistance

ADDITIONAL AUTHOR: John Woods

C6
Environmental Issues in Income Generation and Health

Water Hyacinth: Its Constraints and Opportunities on Health

STEPHEN OTIENO OKOTH

LEARNING OBJECTIVES: Participants attending this session will be able to learn the effect of water hyacinth on health and how the local communities respond to these effects.

BACKGROUND: Water hyacinth is an invasive and neotropical weed of fresh water. By the end of the 20th century, it had become a national issue in Kenya. The weed has affected the socio-cultural and economic fabric of the communities living around Lake Victoria. It poses both constraints and opportunities on the local communities. This study investigated the effect of water hyacinth on access to clean drinking water, the diseases related to its microhabitat and its effect on the accessibility to health care.

METHODOLOGY AND RESULTS: Purposive sampling design was used in the data collection due to the inability to access a complete and up-to-date sampling frame of the households in the area of study. Questionnaires of 200 households were used, of which 40 were drawn from each of the five locations in the area of study. The units of analysis included heads or representatives of households. These included fishermen, farmers, domestic water collectors and artists. The data were collected through observations, interviews and focus group discussions. The data analysis was mainly qualitative. The study found that water hyacinth: pollutes the water, making it unsafe for human consumption; forms an ideal breeding ground for mosquitoes, leading to insurgence of malaria; and creates a conducive habitat for snakes and crocodiles, posing health risks to fishermen and water collectors. However, the weed equally provides an opportunity for the enhancement of the community's living standards through using it in making various products (e.g., baskets, wall mats and furniture).

CONCLUSIONS: Water hyacinth poses a greater impact on the health of communities living around Lake Victoria. However, the weed is also the source of raw material for making various products that enhance the living standards of these communities. The study recommended that there is need for participation by all stakeholders in managing the water hyacinths issue, with more emphasis being given to the local communities' initiatives and the need for the local communities to receive health education to enhance their understanding on the issues associated with the weed.

ABSTRACTS

C6
Environmental Issues in Income Generation and Health

Three Model Approaches for Effective Integrated Development in Madagascar

TINA HARINJAKA RAKOTONANDRASANA

LEARNING OBJECTIVES: Participants will understand the principles and the effectiveness of three integrated community approaches, which facilitate the participation of peasant families in development activities and improve their livelihood.

BACKGROUND: Poor villages in Madagascar have experienced many sectoral development projects. Participatory research has shown that families spend much of their time on subsistence farming and modest income-generating activities following habits formed over generations. Individuals have little incentive to change current practices that could result in greater food security and better health. According to data from a baseline household survey, over half of those interviewed practice slash and burn to cultivate and know about its negative impact on the environment and food production. To change health and natural resource management practices as rapidly as possible, local NGOs rely on early adopters of positive behaviors to set examples for others and on self-motivating techniques. Three model approaches have been used successfully to integrate health, population and environment interventions at the community level. The 'Voahary Salama Champion Community' approach helps communities to set realistic targets, monitor progress and celebrate health and agricultural achievements when targets are reached. Lessons learned from a first group of 16 villages show when and how communities achieve champion status and the obstacles encountered. The 'Child to Community' approach has not only changed pupils' behavior related to health and the environment, but influenced their families as well. Favored examples of better practices are handwashing after defecation and vegetable gardens that improve the nutritional value of children's daily diet. The 'Farmer to Farmer' approach relies on farmers as resources for peers. Model farmers serve as educators, facilitators and innovators. They practice what they preach to convince others of the feasibility and benefits of new agricultural techniques. Because of the integrated nature of the program, they may also become early adopters of family planning, as household survey data indicate.

CONCLUSIONS: These three model approaches to achieve sustained behavior change at the household level rely on four success factors: 1) adapting existing best practices in the health and agricultural sectors; 2) small and doable actions that people can take in a resource-poor environment; 3) simple messages communicated through several channels using materials that are culturally appropriate and attractive; and 4) cross-training of NGO field workers to broaden the target audiences.

PARTNER: Association Voahary Salama

ADDITIONAL AUTHORS: Volonirina Rajaonarivo, Lydia Randrianja, Haja Radaniela

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D1
Enhancing HIV/AIDS Drug Access Through Regional Pooled Procurement

Reducing the Cost of Pharmaceuticals Through Pooled Procurement

FRANCIS BURNETT

LEARNING OBJECTIVES: By the end of the presentation, participants will be able to describe the factors that are essential for successful multi-state pooled procurement of pharmaceuticals as a cost-containment strategy.

BACKGROUND: Financial constraints have made it increasingly difficult for developing countries to adequately finance the supply of drugs to health facilities. The countries comprising the Organisation of Eastern Caribbean States (OECS) have recognized that by implementing more efficient procurement practices, improved use of limited resources is possible. Of the four areas of drug supply management, which include selection, procurement, distribution and use, efficient procurement provides the greatest opportunity for cost savings. The OECS/Pharmaceutical Procurement Service (OECS/PPS) is a self-financing public sector monopsony or buyers' cartel that covers its operating cost from a 15 percent surcharge.

CONCLUSIONS: After 16 years of successful centralized tendering for pharmaceuticals and related medical supplies, the experience of the Eastern Caribbean countries has demonstrated that improved procurement can reduce costs and enhance the efficiency of health service delivery. The critical success factors for pooled procurement are political will, financial commitment, restricted international tendering, institutional alliances among key government ministries, harmonization of drug formularies and a common regulatory framework. Against the backdrop of severe difficulties confronting the global economy and the subsequent negative impact on developing countries, resource-constrained countries should explore all strategies for efficiently utilizing their scarce health sector resources. Better procurement methods have been shown to produce significant cost savings.

PARTNERS: USAID, Management Sciences for Health

D1
Enhancing HIV/AIDS Drug Access Through Regional Pooled Procurement

Pooled Procurement of Antiretrovirals: Opportunities and Challenges

JAMES FITZGERALD

LEARNING OBJECTIVES: Participants will have a better understanding of current procurement practices in the supply of HIV/AIDS antiretrovirals (ARVs) and be able to identify specific issues that need to be addressed before countries and regions can move toward pooled procurement as an appropriate supply mechanism. Participants will recognize the potential contribution of specific forms of pooled procurement in rapidly improving access to ARVs, within the framework of a comprehensive approach, as well as of international and national organizations, agencies and NGOs working with governments to promote the supply and rational use of ARVs.

BACKGROUND: As countries move toward a more comprehensive approach to tackle the present and future burden of HIV/AIDS, authorities are examining possible options in ensuring continuous, reliable and affordable supply of high quality ARVs. In addition to considering technical and administrative issues in product selection, quantification and tendering, authorities have to deal with differential pricing policies, intellectual property considerations and drug quality issues before selecting the preferred source of ARVs. Many countries have inadequate information and capacity to make informed decisions and as a result, the procurement process itself acts as a barrier to improve access to ARVs. The Pan American Health Organization recognizes the importance of pooled procurement, to complement technical cooperation in health systems and supplies management and to facilitate the achievement of objectives in priority public health programs. As of yet, pooled procurement of ARVs has not been possible, as differential pricing policies are not coherent with the principles of pooled procurement. This, however, is changing as countries come together to enter price negotiations with suppliers at the sub-regional level, with the support of international and national institutions, agencies and NGOs, and consider all options in the supply of ARVs including generics, which are not subject to differential pricing. As prices are standardized, the door is opened for countries to benefit from developing pooled procurement mechanisms.

CONCLUSIONS: Pooled procurement of ARVs is only now possible within some sub-regions of the world, but will in the future develop at the global level to ensure a continuous supply of low cost ARVs.

D1
Enhancing HIV/AIDS Drug Access Through Regional Pooled Procurement

Pooled Procurement in Africa: A Commodity Management Solution?

HELENA WALKOWIAK

LEARNING OBJECTIVES: Participants will gain a better understanding of the challenges and benefits of pooled procurement for HIV/AIDS drugs and other related supplies. They will be able to recognize the implications of pooled procurement in improving commodity management of AIDS-related and other essential drugs, and understand the process used to determine the feasibility of implementing a pooled procurement scheme in resource-constrained nations.

BACKGROUND: In Africa, one of the greatest challenges to addressing the AIDS epidemic is making HIV-related and other essential medicines available to the people who need them. Management Sciences for Health's Center for Pharmaceutical Management, in collaboration with the Commonwealth Regional Health Community Secretariat (CRHCS) for Eastern, Central and Southern Africa, a regional intergovernmental organization comprising 14 states, examined the feasibility of instituting a region-wide procurement approach for HIV/AIDS-related health commodities, with a specific focus on antiretroviral drugs (ARVs). Through a series of assessments of existing procurement practices and identification of commonalities and differences among CRHCS countries, a strategy for facilitating regional pooled procurement was developed. A forum of the 14 member countries for ongoing discussions relating to pharmaceuticals regulation, access and use was also established.

CONCLUSIONS: Underlying this pooled procurement initiative is recognition that the vast majority of people living with HIV/AIDS in developing countries do not have access to the drugs and commodities that could prolong and improve their lives. Improving access to HIV/AIDS-related drugs and commodities for people in these settings presents many challenges, including many directly related to commodities management. The experience in working with CRHCS shows that given the political will and acceptance of the need for transnational collaboration on purchasing expensive, often sole-source medicines for HIV/AIDS, then establishment of a regional pooled procurement system is feasible. Harmonization of standard treatment guidelines and building on existing regional alliances is important to success. In addition, the creation of a platform for ongoing resolution of issues among the collaborating countries is essential. The lessons learned from the commonwealth's experience have implications for other regions and countries facing similar challenges in improving access to drugs and fighting HIV/AIDS.

PARTNERS: CRHCS, USAID, Rockefeller Foundation, Management Sciences for Health

ADDITIONAL AUTHORS: Douglas Keene, Michael Gabra, Michael Thuo, Christine Onyango

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D2
Local Outbreak: Community-Based Strategies to Address Infectious Disease

Battling Tuberculosis on the Frontlines: Enabling Rural Clinics in South Africa

NOBANZI DANA

LEARNING OBJECTIVES: Participants will be able to identify the performance improvement (PI) approach and assess its merits as a primary strategy to help rural clinics tailor services to their communities and respond to local and emerging health concerns and challenges.

BACKGROUND: Rural clinics are the frontlines in the battle against HIV/AIDS and tuberculosis (TB) in South Africa. An epidemic of TB struck South Africa on the heels of the HIV/AIDS pandemic just as these clinics were being established by the government as the main outlets for primary health care (PHC). Due to their isolation and the legacy of a previously centralized health care system, the clinics had scant resources to properly direct PHC and combat sexually transmitted infections (STIs)/HIV and TB. Working with the South Africa Department of Health's EQUITY Project, Intrah implemented a PI approach to establish better TB prevention and management services at five model clinics in Eastern Cape Province. Meetings with clinic stakeholders identified performance gaps, including poor utilization of STI services, lack of clinic space for proper consultations and inadequate provider knowledge of TB diagnosis and treatment. After determining the root causes of the gaps between desired and actual performance, stakeholders devised and implemented interventions to address these problems and maximize resources.

CONCLUSIONS: Through clinic-community collaborations, communities became much more involved and committed to their clinic's mission. The PI approach created more self-sufficient clinics that could direct quality of care in response to localized challenges in service delivery. Because the approach works according to a framework, it is easily replicated in similar programs and interventions throughout the world.

PARTNERS: South Africa Department of Health (EQUITY Project), USAID, Management Sciences for Health

ADDITIONAL AUTHORS: Ntomboxolo Dweba, Nobanzi Dana

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D2
Local Outbreak: Community-Based Strategies to Address Infectious Disease

Gold, Diamonds and Migrant Labor: A Recipe for HIV/AIDS

SAMUEL DUH

LEARNING OBJECTIVES: Participants attending this session will be able to: identify the factors (social/societal) that make mining areas prone to sexually transmitted infections (STIs)/HIV/AIDS; understand the concept of Societal Perspective Involvement and Action (SPIA); state the principle of SPIA; and know why SPIA works.

BACKGROUND: Mining areas in Ghana, like those of other countries in Africa, have higher than average rates of STI/HIV/AIDS due to migrant work, high disposable income and high rates of transactional sex. CARE/Ghana has been applying the principle of SPIA in two mining areas in Ghana for STI/HIV/AIDS prevention and control. SPIA is based on the communities' own perspective or diagnosis of their problems, their definition of the causes of the problems and opportunities that exist for addressing the problems. A variety of societal and community institutions review the societal factors that influence sexual and gender interactions, and take steps to improve the social environment for safer sex. This presentation focuses on one of the projects, the Ashanti Region Community Health (ARCH) project.

CONCLUSIONS: The ARCH project has achieved remarkable results through the SPIA process where the communities have taken ownership of the process to sustain the results. Some of the results are: 1) improved knowledge on preventive sexual practices among miners and their partners; 2) improved parent-child and spousal communication; 3) increased use of condoms; and 4) decreased prevalence of STIs. The SPIA concept is easily adoptable since it is based on a societal perspective. It can be replicated in any setting, especially at places where social and cultural practices affect health. Unless such practices are taken into consideration, programs to affect the health status of the population are not likely to achieve significant results. And the consideration of those practices are best approached from the communities' own perspective.

D2
Local Outbreak: Community-Based Strategies to Address Infectious Disease

Community-Based Dengue Prevention in the Dominican Republic

JULIA ROSENBAUM

LEARNING OBJECTIVES: Participants will understand how a specific health behavior-change methodology was applied to develop a community-based dengue prevention strategy.

BACKGROUND: In the Dominican Republic, urban residents use large drums to store water, providing key breeding sites for Aedes aegypti mosquitoes that transmit dengue fever. Negotiation of improved practices is a behavior-change tool characterized by audience segmentation, providing audiences with a range of effective and feasible options based on existing practices, linking them to perceived benefits relevant to people's every day realities, negotiating with them on the adoption of one or more such practices according to their circumstances and enabling them to modify selected practices to the degree they continue to be effective for dengue control.

METHODOLOGY AND RESULTS: Fifty-two in-depth interviews were conducted in urban neighborhoods followed by 20 direct observations of water storage practices. Household bleach was a common agent used to clean water storage containers, but did not kill mosquito larvae and eggs in the quantities and ways it was used. Homemade covers for drums protected water from debris and pests but did not block mosquito entry. Respondents were more concerned with water cleanliness and less concerned about dengue in the absence of an outbreak. Laboratory studies demonstrated the ovicidal effect of undiluted household bleach when applied directly on container walls. Based on these findings, four behavior modalities were negotiated in small-scale trials with 20 households: two types of low-cost covers and two methods for weekly application of bleach. After the trials yielded encouraging results, the two bleach application behaviors were adopted by the National Dengue Control Program.

CONCLUSIONS: Preliminary feedback from communities implementing the national strategy suggests that the interventions are well accepted and are reducing mosquito infestation levels. Interventions based on pre-existing practices and negotiation with segmented audiences have a better chance for adoption and sustainability than interventions not developed in this manner.

PARTNERS: Secretariat of Health and Social Assistance, Dominican Republic, USAID, Pan American Health Organization, Academy for Educational Development, Johns Hopkins University, Dengue Branch of the Centers for Disease Control and Prevention

ADDITIONAL AUTHORS: Elli Leontsini, Guillermo Gonzalvez, Antionio Solis

D3
Healthy Families, Healthy Forests: Integrated Programs

Working Together: Family Planning and Natural Resource Management

ODILE RANDRIAMANANJARA

LEARNING OBJECTIVES: Participants will understand the advantages, feasibility and effectiveness of implementing community-centered programs that link family planning with natural resource management objectives.

BACKGROUND: Madagascar's few remaining forest resources are vital for protecting a unique biodiversity and watersheds with associated agricultural systems. However, these precious resources are threatened by rapid forest losses, mainly due to population pressure, destructive agricultural practices and inadequate private and public sector responses. For example, baseline surveys show that food security is a major concern with half of the children under five malnourished and the majority of households using forest destroying slash-and-burn practices; fertility is high and contraceptive prevalence is as low as two percent in the areas concerned. To address these issues, national NGOs under the Malagasy association 'Voahary Salama' implemented a program that integrates population, health and environment interventions at the community level around biologically diverse ecosystems. The adoption of desirable practices, such as family planning or nondestructive farming methods, relies on the 'innovator model' employing various social marketing techniques, such as champion communities, child-to-community and farmer-to-farmer education, and model families. Three types of integration are tested and compared to communities without integrated approaches.

CONCLUSIONS: NGOs have been the key to a rapid scale up of integrated interventions within the first two years of the program, reaching a population of 50,000 in over 120 rural communities. Cross-training of field agents has become a core activity for creating competencies that complement the sector-specific technical knowledge of these workers. Polyvalent community animators work with local leaders and organizations to mobilize communities; and community-based distributors increase access to contraceptives. Farmer groups hear about family planning in addition to learning about improved agricultural practices, and school children carry messages about improved natural resource management practices back to the community. Activities and accomplishments are monitored routinely and key findings will be reported. Successful integration builds on few interventions and simple actions that people can take with the means available. The Voahary Salama Association is critical in strengthening the technical and organizational capacity of NGOs, sharing experiences and replicating best practices in integrated approaches.

PARTNERS: ADRA, ASOS, Mateza, MCDI, MICET, SAF, Tany Meva, Packard and Summit Foundations, National Office of Population

ADDITIONAL AUTHORS: Bienvenu Razafitsialonina, Eckhard Kleinau

ABSTRACTS

D3
Healthy Families, Healthy Forests: Integrated Programs

Community-Centered Conservation: The Jane Goodall Institute-Tacare Experience in Tanzania

GEORGE STRUNDEN

LEARNING OBJECTIVES: By the end of the presentation, participants will be able to recognize the importance of participatory approaches in design and implementation of conservation and reproductive health projects.

BACKGROUND: The Jane Goodall Institute (JGI) initiated the Tacare project in 1994 with funding from the European Union. It was designed as a pilot project to seek ways of arresting the rapid degradation of natural resources, especially the remaining indigenous forest in the Kigoma region of Tanzania. The area is widely deforested as a result of clear cutting for cultivation purposes and the use of firewood for domestic and fish processing purposes, compounded by additional pressure on natural resources caused by the influx of refugees from the Democratic Republic of Congo and Burundi. Since early 1999, the Tacare project has entered its second phase and has moved toward a more multilateral approach, involving the communities in their own socioeconomic development. Participation of communities and local government technicians played a central part during the design and implementation phase. During participatory planning sessions, it was found that social infrastructure, access to clean water, education and primary health care were rated higher than conservation issues. The overall objective of the project is to improve the quality of soil and biodiversity through productive and sustainable natural resource management and rural production systems.

CONCLUSIONS: A prerequisite for successful and sustainable project intervention is to take community participation seriously. In order to achieve community participation in conservation or reproductive health projects, priorities expressed by communities have to be considered and addressed in project activities. Offering project services in fields prioritized by the community creates trust toward the project and enhances participation in areas ranking lower in the scale of priorities.

PARTNERS: Local government, project staff, communities in the project area

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D3
Healthy Families, Healthy Forests: Integrated Programs

Health and Hotspots: Why Family Planning Matters to Conservationists

JOHN N. WILLIAMS

LEARNING OBJECTIVES: Inform participants about the approach of an international conservation organization (Conservation International, CI) toward combining reproductive health and family planning with existing natural resource conservation strategies in its field programs.

BACKGROUND: The goal of CI's population-environment program is to reduce the impact of human population pressure on areas of high biological diversity, specifically in the hotspot and wilderness areas where CI focuses its conservation efforts. We seek to achieve this goal by evaluating demographic pressures and integrating reproductive health activities into our ongoing conservation strategies in these priority areas. Where possible, we link communities with local and national government services in voluntary reproductive health and family planning. Where government services are not available, we help NGOs establish reproductive health and family planning services within these communities. This presentation details CI's population-environment philosophy, methodology and approach to field programs, drawing on examples and lessons learned from our experience to date.

CONCLUSIONS: Although it has taken a long time for conservation organizations to start addressing human population growth directly, CI has found that it is both possible and relevant to do so. Such interventions raise awareness, help relieve population pressures and yield tangible improvements in crucial areas such as maternal and child health. Thus, not only do these themes have considerable programmatic overlap, but they are also linked in the minds of people living around protected areas. Furthermore, the donor community is interested in the intersection of these two fields and as a result, is willing to provide additional funds to both conservation and reproductive health organizations that would not otherwise be available.

PARTNERS: In-country NGOs and government agencies, such as MEXFAM and the Mexican Social Security Institute in Mexico, AAPROFAM, Ministry of Health, Guatemala

ABSTRACTS

D4
Looking at Laws: Issues in Human Rights, Health and the Environment

Medical-Legal Documentation of Human Rights Abuses by Transnational Corporations

KATHLEEN ALLDEN

LEARNING OBJECTIVES: Participants attending this session will be able to understand that United States transnational corporations that commit human rights abuses outside the U.S. can be sued for damages. Using the example of the Yadana gas pipeline in Burma, participants will be able to understand how they can utilize the new United Nations protocol on investigation of torture and cruel punishment to document human rights abuses by transnational corporations.

BACKGROUND: To explore and exploit a region's natural resources, transnational corporations negotiate partnerships with governments that have records of severe human rights abuse. Using the Alien Relief Act, non-U.S. residents can bring suit against U.S. corporations for abuses that occur outside of the U.S. Refugees and displaced persons are currently bringing suit against transnational oil companies operating in developing countries in Asia and Africa. In a precedent-setting human rights case in U.S. courts, Burmese refugees in Thailand are suing the Unocal corporation for forced labor, forced relocation, torture, rape and wrongful death that allegedly occurred during the construction of the Yadana gas pipeline in Burma. To document pain and suffering and to prepare expert testimony, psychological evaluations were performed on all the plaintiffs using methods outlined in the new UN document 'Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,' also known as the Istanbul Protocol. The author, who drafted the psychological evidence section of the Istanbul Protocol, utilized its methodology to assess the psychosocial impact of the pipeline construction on all plaintiffs. The evaluations were performed in Thailand at the Burma border where the plaintiffs have fled. This paper will describe the author's findings and discuss the role of the health professions in medical-legal documentation of human rights abuses by transnational corporations.

CONCLUSIONS: The consequences of the atrocities committed during the construction of the natural gas pipeline have long-reaching psychological and psychosocial effects on those who were forcibly displaced and harmed. The initial traumas experienced by those harmed have been followed by years of suffering and hardship as internal displaced persons or as 'illegal immigrants' in Thailand. The Istanbul Protocol provides a useful guide for health and mental health professionals to document health, mental health and psychosocial consequences of human rights abuses. This information can be helpful in prosecuting human rights abuses by transnational corporations.

PARTNERS: Earthrights International, Center for Constitutional Rights

D4
Looking at Laws: Issues in Human Rights, Health and the Environment

Health and the Environment as Human Rights

CURTIS DOEBBLER

LEARNING OBJECTIVES: Participants attending this session will be able to understand the connection between human rights, their social environment, health, and government spending and regulation of the private sector. The concentration will be on presenting the legal framework for the protection of human rights to health and the environment. Both of these rights have been widely agreed upon by countries ratifying legally binding human rights treaties, such as the International Covenant of Economic, Social, and Cultural Rights and the African Charter of Human and Peoples' Rights. How these legal norms can be used to influence policy-making and public action as well as what action is required or encouraged will become apparent through the examination of these norms.

BACKGROUND: Social policy will be considered in light of the human rights obligations by which states have agreed to abide, with special attention on long-term planning and progressive implementation strategies. Environmental policy will be considered in light of the human rights obligations by which states have agreed to abide with special attention to the African and Indian forums where environmental rights have been made judiciable. Health policy will be considered in light of the human rights obligations by which states have agreed to abide with special attention to health spending and regulation of the private sector. Fiscal policy will be considered in light of the human rights obligations by which states have agreed to abide, with attention to the prioritization of spending that is required by a state's human rights obligations.

CONCLUSIONS: It is important to understand why and how to distinguish between different levels of priorities in policy and spending using international human rights obligations as the basis for these distinctions. Participants will learn how to make simple and rational policy arguments using the legal norms of international human rights law, and to apply international human rights law to specific policy-making contexts. Participants will understand how to measure the effective achievement of human rights goals in the framework of environmental and health policy, and the close connection between human rights to environment and health.

PARTNERS: No partners have worked with me on this study to date, but it is intended to enlist the participation of members of the international human rights community to put together a panel. It is expected that such NGOs as the New York-based Center for Social and Economic Rights will participate.

ABSTRACTS

D4
Looking at Laws: Issues in Human Rights, Health and the Environment

Environmental and Occupational Health in Poland

GABRIELA KERNAN

LEARNING OBJECTIVES: Participants attending this session will be able to demonstrate knowledge about Polish environmental and occupational health requirements and regulations.

BACKGROUND: Environmental and occupational health risk assessment is in early development in Poland. Exposure level measurement in plants is a relatively new practice, and environmental health is not taken into account. As such, it is very difficult to prove that the work setting is mainly responsible for particular health damage, and therefore apply for corresponding compensation. Nevertheless, companies that undertake economic activity in Poland now and in the future will face significantly greater risks. European Union law will require that health issues are taken into account. Whereas theoretically the health of workers in occupational settings has been regulated, in practice workers are often overexposed to various substances. Often workers are not aware of occupational hazards, nor are they cognizant of the link to the workplace due to adverse changes in health. Only in a limited number of cases did workers obtain compensation following prolonged illnesses. The typical compensation in such cases is US$70 per month per person, when the average monthly earning in Poland is about US$1000. Silesia, located in the southwestern part of the country, is one of the most populous and polluted regions in Poland. There are locations where the anthropogenic layer is 8-10 m thick from activities associated with past or present coke plants, smelters, lead and zinc mining, and chemical reprocessing wastes in operation from the 13th century. Historic waste dump areas posing a direct health risk are found even in the downtown sections of a large town. Although environmental issues are being slowly recognized, the aspect of human health is being omitted. Just recently, new strict, yet flawed, environmental regulations have come into force introducing contaminated land regime. Based on these regulations, remedial action is required if one of the specified parameters is breached. Unfortunately, the environmental risk assessment can be applicable only in very rare situations and does cover or include human health risk assessment. Thus, for instance, redevelopment of sites such as shipyards into residential commercial areas is done without assessing any health risk.

CONCLUSIONS: The current environmental and health risk management situation, although changing, still poses a risk for industrial entities investing or doing business in Poland. Often environmental/health issues are omitted in the transaction process and assessments are not conducted. According to current rules, the owner or the leaser is liable and lack of knowledge can no longer be treated as an excuse.

D5
Local Solutions: Communities Impacting Child Survival

Effective Community Mobilization for Health Action in Larger Communities

PAUL MKANDAWIRE

LEARNING OBJECTIVES: Participants attending this session will be able to identify at least three ways to effectively mobilize larger, rural, isolated sub-Saharan African communities for health behavior change.

BACKGROUND: Malawi suffers the highest child mortality rate among African nations eligible for child survival programs. The people of Northern Malawi are especially disadvantaged; not only do they have limited access to political power and government services, but there is also less NGO involvement in their region. A four-year community-based behavior change communication program was implemented to reach out to larger communities in this area. The Tiweko Tose Child Survival Project focused on training a network of volunteers through care groups, implementing and institutionalizing the hearth program, and instituting a community-based health management information system.

CONCLUSIONS: More than 30,000 households were reached with effective health messages through a network of volunteers in care groups. After two years, there was an increase in health care-seeking behavior and a reduction in child mortality rates as observed by the local authorities. Discussions at all levels indicated that there was a perceived and real improvement in health status, including increased referrals of emergencies and decreased mortality due to malaria. The project also demonstrated that the care group structure can be successfully implemented in Malawi as a social movement for behavior change. For instance, the percentage of children under five years treated the same day or the next day for fever (suspected malaria) increased from 35 percent to 52 percent, and the project increased modern contraceptive use from 23 percent to 50 percent. In this area of low access to political power and government services and low NGO involvement, community mobilization for health action using a network of volunteers proved a very effective model of reaching larger communities. A care group structure can be used in larger communities, especially in rural sub-Saharan Africa, as a means to bring health messages to people's doorsteps rather than to outreach clinics.

PARTNERS: World Relief Corporation, CCAP Livingstonia Synod Hospitals, USAID

ADDITIONAL AUTHORS: Victor Kabaghe, Heather McDaniel, Melanie Morrow, Anbrasi Edward Raj, Kathryn Norgang, Meredith Long

ABSTRACTS

D5
Local Solutions: Communities Impacting Child Survival

Child Survival: Empowering Communities to Take Action

MELANIE MORROW

LEARNING OBJECTIVES: Participants attending this session will be able to identify at least three ways in which communities can be empowered to improve their own health.

BACKGROUND: Widespread poverty, a patriarchal society, harmful cultural practices, social disruption caused by war and migration, and the devastation brought about by recent floods and current famine all contribute to high rates of infant and maternal morbidity and mortality in Mozambique's rural district of Chokwe. The Vurhonga II Child Survival Project (1999-2003) is lowering these rates by helping 47 communities in Chokwe create 220 care groups to train 2,800 volunteer mothers and church leaders as behavior change agents to all households, as well as by strengthening the capacity of the Mozambique Ministry of Health (MOH) to implement child survival interventions. By working through social networks and partnering with community organizations and the MOH, Vurhonga II aims to empower communities to improve their health and revise cultural beliefs and practices harmful to health.

CONCLUSIONS: By midterm evaluation (2001), the Vurhonga II project established a network of about 200 care groups with 2,350 volunteer mothers trained to counsel behavior change related to malaria, diarrheal diseases and nutrition. The external evaluator found that overall, all of the specific targets for these three interventions were achieved or surpassed. For example, the children sleeping under insecticide-treated nets year-round increased by 68 percent, the proportion of children with diarrhea treated with oral rehydration therapy increased from 53 to 80 percent, and the number of malnourished children's mothers receiving nutritional counseling increased from 22 percent to 80 percent. Moreover, the project made significant progress in building the capacity of its community partners (the MOH and churches) and in helping all but four villages to form health committees that met regularly and utilized ongoing project data to identify and address problems in their villages. This progress suggests sustainability of project activities. Although the ongoing famine is creating new challenges for Vurhonga II, its noteworthy progress and high level of community support attest to the importance of engaging the community, its members and its organizations as the primary agents of behavior change and social environment modification.

PARTNERS: World Relief Corporation, Mozambique MOH, USAID

ADDITIONAL AUTHORS: Pieter Ernst, Ambrasi Edward-Raj, Meredith Long, Heather McDaniel, Kathryn Norgang

D5
Local Solutions: Communities Impacting Child Survival

Extending Child Health Services into Nigerian Communities

DAIYABU MUHAMMED

LEARNING OBJECTIVES: By the end of the presentation, participants will be able to identify key elements required to engage communities in child survival activities.

BACKGROUND: Traditionally, the Nigerian Ministry of Health (MOH) has focused on delivering child health services through primary health care units located within the nation's 774 local government areas (LGAs). Despite the MOH's best efforts, child health indicators in immunization, nutrition and communicable disease control have remained among the lowest in Africa. In 2001, BASICS II in collaboration with the MOH and the Nigerian Primary Health Care Development Agency (NPHCDA) started a community-based initiative to develop partnerships between the members of the community and the public/private sector providers located within the catchment areas of the government primary health care units. Known locally as 'Catchment Area Planning and Action (CAPA),' the initiative is now active in 20 LGAs of three states and the NPHCDA has been encouraged to extend the program nationally to Nigeria's 120 million inhabitants. CAPA relies heavily on strong community partnerships in which investments are made in public education, community-based planning, orientation of providers to community-based health services, strengthening of referral services and a volunteer health promoter system. Although the program is focused on child survival objectives, it is a platform that could promote other important initiatives, such as HIV/AIDS prevention, maternal health and sanitation. The presentation focuses on the elements of the program that are important to engage community members in child survival activities and ensure sustainable partnerships with the national and state health providers and the wealth of private sector health personnel who are their neighbors.

CONCLUSIONS: Within two years, CAPA has become active in 222 catchment areas of Nigeria's most populous LGAs and reaches nearly 6 million people, of whom 1.4 million are children under five years of age. Lagos, Kano and Abia states have adopted the approach, and NPHCDA plans to extend the program to the entire country. Several indicators including breastfeeding rates, vitamin A intake, insecticide-treated materials use and immunization have increased in the areas where CAPA is being implemented.

PARTNERS: BASICS II, Nigerian MOH, NPHCDA

ADDITIONAL AUTHOR: Andy Agle

ABSTRACTS

D6
Water, Livelihood and Health

Sustainable Health Benefits from Community-Managed Water Systems in El Salvador

RICARDO MANCÍA

LEARNING OBJECTIVES: Participants will know the factors that influence the sustainability of community-managed water and sanitation systems and how changes in hygiene behavior are being sustained in order to reduce the incidence of diarrheal diseases in children under five years of age.

BACKGROUND: In April 1998, CARE/El Salvador entered into a cooperative agreement with USAID/El Salvador to implement a sustainable water and sanitation program in rural areas of El Salvador. This program is called 'PROSAGUAS,' a Spanish acronym meaning 'program for health through water and sanitation.' The purpose of the program is to reduce diarrheal diseases in children under five through the introduction of potable water, basic sanitation, environmental activities and health education. About 28,000 people have gained access to latrines and 49,000 have household water connections through the program. Sixteen out of the eighteen water systems constructed are managed by the nonprofit water boards appointed by the communities that they serve. Particular attention has been paid to maintaining the health benefits of the program as well as sustaining the infrastructure and the watershed. Project staff have worked together with leaders, local governments, NGOs and the Ministry of Health (MOH) to provide basic health education to the adult and adolescent population, to disseminate knowledge related to the prevention of children's prevalent diseases, to increase awareness of the importance of a healthy environment, and to promote an entrepreneurial approach and social vision for the administration, operation and maintenance of the water and sanitation systems, and reforestation of the areas surrounding water sources. An important innovation is the biannual evaluation of health achievements in each community.

CONCLUSIONS: When potable water and sanitation systems are formulated and executed with communities in response to their demand, they are more likely to be sustainable. When basic health and environmental education is an integral part of the implementation strategy, poor communities are willing to pay a water tariff that includes an investment in health and the environment, complementing the MOH efforts. And the program reduction of diarrheal diseases is at least 26 percent.

PARTNERS: Community organizations, municipalities, national government institutions, USAID, Rotary Foundation, International Lions Club, European Union Project, local NGOs, program staff

ADDITIONAL AUTHORS: Marvin Mejía, Jonathan Claros

D6
Water, Livelihood and Health

The Village Coverage Approach for Water Supply and Sanitation Systems, State of Gujarat, India

ANITA MIYA

LEARNING OBJECTIVES: Participants will understand the concept, rationale and processes of the 'Village Coverage Approach' in water supply, sanitation and hygiene education.

BACKGROUND: In Gujarat, the results of water supply and sanitation interventions have been disappointing. The physical infrastructure is often nonfunctional, and anticipated benefits in terms of heath and quality of life are not evident. The target-driven approach, applied by the government and service providers, has led to several unfortunate consequences, namely: 1) an integrated package, combining water supply infrastructure, sanitation infrastructure, community capacity-building and hygiene promotion, has been denied to communities; 2) different and sometimes competing service delivery agencies reduce the potential for integration and coherence of benefits; and 3) communities are not involved meaningfully in decision-making or project implementation. Most communities are passive recipients of goods and services rather than active partners in a broader development process.

METHODOLOGY AND RESULTS: The Gujarat Environmental Health Improvement Programme (GEHIP) employs an integrated and participatory methodology to provide water supply and sanitation services to rural communities in 125 villages in Gujarat, India. The current two-year validation phase of the program is testing and refining a Village Coverage Approach to enhance the capacity of communities to deliver and sustain program interventions. The program mobilizes communities to prepare and implement a Village Action Plan (VAP) that outlines the community's long-term vision for meeting environmental health and water management needs, and details specific tasks related to the implementation, commissioning, initial operation and maintenance of the systems. The VAP is developed in consultation with the Village Development Committee and, once signed by all the parties, becomes the agreement that defines roles and responsibilities and promotes cooperation among the community, governmental institutions, including Panchayati Raj institutions, and Aga Khan Planning and Building Service, India (AKPBS,I).

CONCLUSIONS: The Village Coverage Approach incorporates principles of sector reform, responds to community concerns and offers the promise of establishing sustainable rural water supply and sanitation systems and effective hygiene practices.

PARTNERS: AKPBS,I, the village development communities, local government institutions

ADDITIONAL AUTHORS: John B. Tomaro, Nemat Hajeebhoy

D6
Water, Livelihood and Health

Women-Managed Sanitation Project in Rural Bangladesh

REBEKA SULTANA

LEARNING OBJECTIVES: Participants will be able to learn how a paradigm shift can expand active participation and involvement of rural women managing environmental sanitation problems.

BACKGROUND: The health risks among children and women due to the environmental hazards associated with lack of safe and hygienic sanitation facilities in Bangladesh are high. Poor water and sanitation accounts for higher mortality and morbidity among this group due to diarrheal diseases, typhoid, helminthiasis, hepatitis, etc. Moreover, social environments and low status in the family play an equally important role in influencing the accessibility of hygienic sanitation facilities for rural women. In Plan Bangladesh areas, baseline data show that only 25 percent of rural families use sanitary latrines. The practice among the women and children are even lower due to the societal factors that hinder especially women from using sanitary latrines during the day. They wait until dark and usually go to the bushes for open defecation. Children in rural areas are habituated in open defecation as well. The situation is also complicated by the social norms that women cannot use the same toilet used by senior male members of the family. Through continuous facilitation by Plan, women have identified poor sanitation facilities in their community as a priority problem and decided to solve this with support from Plan. Women's groups of 10-15 members were organized. Children's groups were formed to perform various social mobilization activities. Local government officials are also actively involved in the awareness-raising campaigns. Group members were equipped with appropriate training on: 1) making sanitary latrines using appropriate local-level technologies; and 2) group savings, accounts and bookkeeping. Plan provided all training to the groups, while the individual group members contributed in installing their own family latrines constructed through the group efforts. The women's groups, with the help of local government and Plan staff, performed monitoring and follow up of the latrines installation and their proper use. Currently 400 marginalized families installed and are using latrines.

CONCLUSIONS: A critical mass of empowered women's groups has been created, which are now role models for other communities. This has created a spill-over effect in the adjacent communities as well.

ADDITIONAL AUTHOR: Shehlina Ahmed

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LEARNING OBJECTIVES: By the end of the presentation, the participants will be able to recognize the importance of chronic powerlessness in designing community-based health initiatives.

BACKGROUND: Community-based clinics strive to engage people in improving their own health. 'Social Capital' is a new public health variable that reflects the existence of trusting horizontal relationships inside communities and is associated with their well-being. However, the 'vertical' relationships with the larger society cannot be ignored. A sample of 50 diabetic adults and 50 asthmatic children, patients of a community health center, and 94 other community members related to them participated in a study. The center serves a large low-income urban Latino population in the United States. Several instruments were applied to explore their social experience: quality of life (SF-36, Euroquol and PedsQL), social networks and self-efficacy. Epidemiological and demographic data of the community were also analyzed.

CONCLUSIONS: The psychosocial component of quality of life was equally low for both, the patients and the nonpatients, suggesting a detrimental effect of the socioeconomic status on the whole community. Furthermore, children's quality of life (especially in the psychosocial realm) seems to decrease as they grow older and attempt social integration. People's trust networks were largely confined to the center's service area, suggesting high social capital and potential community participation. However, the self-efficacy findings revealed an important sense of unpredictability and powerlessness about controlling the future and the forces that give shape to it. This fact needs to be considered when clinics design patient education models, especially for chronic diseases that require long-term care. Also, community participation initiatives must address the sociopolitical realities of the poor and provide education and conscientization about them as ways to invest on social capital.

PARTNERS: Clinic staff, local schools

ADDITIONAL AUTHOR: John Bartkowski

E1
Powering Up: Motivating Communities to Improve Health

Social Capital in Poor Communities: Don't Forget Empowerment

CAROLINA GONZÁLEZ-SCHLENKER

LEARNING OBJECTIVES: Participants attending this session will be able to: list at least five shifts in the paradigm of health delivery for reducing a prevailing infectious disease in their areas; describe steps to form self-help groups to address infectious disease control in their area; and demonstrate through a game how to elicit community participation for infectious disease control.

BACKGROUND: Even after several years of research, infectious diseases such as diarrheal diseases and malaria continue to cause death in remote communities. As an NGO, INSA/India realizes the importance of the communities' perception of infectious diseases, and that their participation in infectious disease control is important in addressing the issue. Through training and consistent follow-up, INSA/India has facilitated participants to look at a community-oriented paradigm of addressing infectious diseases in their areas in India and Nepal. One of the first steps would be to form self-help groups of people within communities for thrift and savings programs through which infectious disease control is addressed. The various levels of community interventions will be discussed and the pros and cons of each will be highlighted.

CONCLUSIONS: Self-help groups are a viable process for addressing community-based infectious disease control. Paradigm shifts in health delivery are necessary for enabling infectious disease control. Interactive methods enable a control program to be truly by and of the people.

E1
Powering Up: Motivating Communities to Improve Health

Health by and of the Communities

EDWINA PEREIRA

E1
Powering Up: Motivating Communities to Improve Health

Building a System of True Community-Based Health Care in Afghanistan

JON E. ROHDE

LEARNING OBJECTIVES: Participants attending this session will be able to describe how a system of true community-based health care can contribute to improved health outcomes in Afghanistan.

BACKGROUND: The 23-year conflict in Afghanistan has largely destroyed the country's health infrastructure, especially outside of the main cities. Due to the lack of any central authority, rural health-care services, where available, are provided by NGOs and local health authorities according to a variety of models and often-conflicting policies. The Ministry of Public Health has recognized the potential of community-based health care (CBHC) to improve health outcomes, and has expressed support for CBHC in its national health policy. It also hopes to learn from Afghanistan's pioneering experience with CBHC in the 1970s, curtailed by the country's descent into war. While most of the differences in models have focused narrowly on the role and compensation of the community health worker (CHW), true CBHC involves an entire system and orientation toward the relationship between the community and its health-care providers, not just the role of one cadre of staff. During a national planning workshop, key government policy-makers from central and provincial levels, Afghan and international NGOs, and their development partners came together to examine international and Afghan experience in CBHC and plan its application in reaching communities within Afghanistan.

CONCLUSIONS: Despite the current fragmentation, the government and NGOs were able to agree on several core principles to guide the development of a true system of CBHC in Afghanistan, including establishing the primary pro-active role of the community, including in the identification, supervision and support for CHWs, balancing the apparently conflicting needs for national uniformity and local flexibility, providing adequate training, oversight and supervision in proximity to more formal health facilities yet as close as possible to the village level, maintaining a sustainable system of compensation, preferably according to traditional methods, and, incorporating the existing network of traditional and modern health providers into the system of oversight and supervision.

PARTNERS: Afghanistan Ministry of Public Health, Management Sciences for Health, UNICEF, WHO, Afghan and international NGOs

ADDITIONAL AUTHORS: Mubarak Shah Mubarak, Paul Fishstein

E2
On the Job: HIV/AIDS Strategies for the Work Environment

Cost-Effectiveness of Peer Educator Programs for Mobile Construction Workers in Vietnam

ANN LEVIN

LEARNING OBJECTIVES: Participants attending this session will be able to assess the difference in cost-effectiveness of two approaches to HIV prevention among mobile construction workers.

BACKGROUND: In Vietnam, construction workers are at risk of sexually transmitted diseases and HIV/AIDS in their environment. These workers are highly mobile, generally unmarried and have low levels of education. In 1998, the Ho Chi Minh City Standing AIDS Bureau began a visiting health communicator program that gave sessions to the workers on how to prevent sexually transmitted diseases and HIV/AIDS. To improve the sustainability and effectiveness of the program, a second approach that utilized peer educators was introduced at some sites in 2001. The hypothesis that is being tested is that the peer education program is more cost-effective than the health communicator program.

METHODOLOGY AND RESULTS: Construction sites were randomly selected from a mapping of construction sites, and sites were randomly allocated to the visiting health communicator and peer education approaches. Data on resource use for each approach were collected and analyzed. These include the costs of starting up the HIV/AIDS projects (training of management and health educators) and operational costs of implementing the program (personnel time, supplies, and transport). The effectiveness of the two approaches was measured through data from baseline and follow-up surveys. The surveys measured change in knowledge and life skills among the mobile construction workers. Using this information, the cost of effecting changes in knowledge and life skills is calculated.

CONCLUSIONS: The findings have implications for the sustainability of health education approaches for mobile workers.

PARTNERS: Population Council, Ho Chi Minh City Labor Union, College of Social Sciences and Humanities of HCMC National University

ADDITIONAL AUTHORS: Vu Ngoc Bao, Philip Guest, Julie Pulerwitz, Le Thuy Lan Thao, Duong Xuan Dinh, Tran Thi Kim Xuyen

E2
On the Job: HIV/AIDS Strategies for the Work Environment

Changing the Environment for the Private Health Sector

MEAGHAN SMITH

LEARNING OBJECTIVES: By the end of this session, participants will be able to identify interventions that improve the role of the private sector in achieving public health outcomes.

BACKGROUND: Traditionally, the private sector has played a limited role in public health in developing countries. Recently, there has been a growing recognition by donors and governments that there are significant opportunities for working with for-profit health service providers. In many countries, the private sector already delivers a range of services with public health implications, such as voluntary counseling and testing (VCT), immunizations and family planning. Consumers, even lower-income ones, frequently prefer the private health sector. Donors and governments are now grappling with how to improve the environment for the private sector in achieving public health outcomes. Working with the private sector requires a new type of programming. Successful interventions need to be documented and disseminated. This session will disseminate the Summa Foundation's experience working with C&J Medicare, a commercial health provider in Accra, Ghana. C&J operates primary health-care clinics in Accra and has built a niche in contracting with companies to provide health care for employees and dependents. C&J's clients are primarily lower-income workers, women and children. By partnering with C&J Medicare, the Summa Foundation recognized an opportunity for scaling up positive health outcomes through the private sector. Summa designed a package of financing and technical assistance in order to: 1) expand services, reaching more women and children; 2) improve family planning service delivery; 3) improve VCT services; 4) increase coverage of family planning services under employer contracts. Summa monitored each of these interventions through pre- and post-tests on training, changes in service statistics and by examining changes in the number of employer contracts that cover family planning.

CONCLUSIONS: Monitoring data from this intervention shows that financing and technical assistance can be used to improve the role of the private sector in achieving positive public health outcomes. This intervention is replicable in other countries as long as the right private sector partner is identified.

PARTNERS: The Summa Foundation, Commercial Market Strategies Project, C&J Medicare

ADDITIONAL AUTHOR: Carlos Carrazana

ABSTRACTS

E2
On the Job: HIV/AIDS Strategies for the Work Environment

Implementing a Workplace-Based AIDS Education Program among Floating Unmarried Young Workers in East China

XIAOMING SUN

LEARNING OBJECTIVES: Participants attending this session will know the effect of a workplace-based peer AIDS education program on the sexual behavior among unmarried young in China.

BACKGROUND: The HIV epidemic in China has seriously spread to all the provinces. Floating population, particularly unmarried young workers, has become a vulnerable group to HIV infection in East China. A workplace-based peer education program was implemented in Kunshan county to evaluate the effects of the program on unmarried young workers' AIDS-related knowledge, attitudes and sexual behaviors.

METHODOLOGY AND RESULTS: The study involved 2,050 subjects aged 18-30 years, who were from 13 provinces of China, were recruited from six factories in Kunshan county and were similar in their socioeconomic characteristics. The six factories were randomly assigned to experimental or control group status. Fifty young adults among 1,050 study subjects in the experimental factories were selected and trained as peer educators. A baseline survey, intervention through peer educators in the experimental factories and a 12-month follow-up survey were conducted. The effects of the program were evaluated by comparing the results of survey data before and after intervention in both experimental and control groups. The baseline survey was conducted in April 2001. The results showed that the AIDS knowledge was not well disseminated among the unmarried young workers, and many misunderstandings existed among them. Their attitudes toward premarital sex were very open, but were relatively conservative toward people with HIV/AIDS. More than 60 percent of them said that it was acceptable to have sex if they were falling in love. Near 25 percent of the total study subjects admitted that they had had sex with their boyfriends or girlfriends. However, of these who had had sex, only 20 percent used condoms during the last episode of sexual intercourse. After the 12-month peer-based AIDS education in the experimental factories, a post-intervention survey was conducted in April 2002. The results showed that the experimental group significantly improved its knowledge and attitudes related to AIDS. Experimental subjects, who were sexually active during the intervention period, reporting condom use during the last episode of sexual intercourse increased from 20 percent at baseline to 50 percent at follow-up ($P<0.05$). No such changes occurred among control subjects.

CONCLUSIONS: The study suggested that the workplace-based AIDS education intervention through peer educators can be successfully implemented among floating unmarried young workers in developing countries with a similar culture.

PARTNERS: Kunshan Family Planning Commission, Jiangsu Province, China

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E3
Malaria, Dengue, Cholera: Environmental Strategies for Control and Prevention

Volcano Eruption in Goma: Avoiding a Cholera Outbreak

FRANKLIN BROADHURST

LEARNING OBJECTIVES: By the end of the presentation, participants will be able to identify three factors instrumental in stemming a potential deadly cholera outbreak in Goma in 2002.

BACKGROUND: Waterborne diseases are major causes of morbidity in natural disasters and complex emergencies in underdeveloped countries. Over 30,000 Rwandans died within three weeks in 1994 in Goma on the shore of Lake Kivu in eastern Democratic Republic of Congo due to an explosive cholera outbreak. This has been purported to be the most acute cholera outbreak ever recorded. The outbreak was blamed on the consumption of untreated, contaminated lake water, and the inability of the relief community to rapidly provide water and sanitation services to such a large population. In January 2002, Mount Nyiragongo erupted in Goma, spilling two streams of lava into the city. The lava flow destroyed 20 percent of the city's surface area and 13,000 homes, disrupted the city's water and electrical infrastructure, and forced the evacuation of 350,000 people for several days. Upon returning to the city, Gomans were faced with increased potential for an infectious disease outbreak. Given the history of Goma in 1994 and the conditions following the eruption, humanitarian and governmental organizations' efforts were focused on preventing another deadly epidemic. Their efforts proved fruitful. Interventions focused first on the rapid provision of safe water. This included installation of emergency water distribution points using rubber bladders filled by water tankers, and the direct disinfection of individual water containers as residents collected water from the lake. These efforts were guided by an extensive data collection scheme that provided spatial information concerning population densities, water consumption and sanitation coverage.

CONCLUSIONS: In analyzing factors critical to the success of epidemic prevention in this situation, three major themes emerged. The first was having a common and clearly definable objective in the first days: the rapid provision of safe water. The second was the speed at which resources (both human and material) were made available to the response. The final critical factor was the use of data acquisition and analysis to monitor, guide and redirect interventions on a daily basis.

PARTNERS: International Rescue Committee field staff, OXFAM, Médecins Sans Frontières, International Committee of the Red Cross

ADDITIONAL AUTHOR: Les Roberts

E3
Malaria, Dengue, Cholera: Environmental Strategies for Control and Prevention

Best Practices in Dengue Prevention and Control

LINDA S. LLOYD

LEARNING OBJECTIVES: Participants will be able to identify best practices for integrated Aedes aegypti control for the prevention and control of dengue and dengue hemorrhagic fever in Latin America.

BACKGROUND: In the past 10 years, the number of dengue fever and dengue hemorrhagic fever (DHF) cases has increased dramatically in Latin America and the Caribbean. Despite the growing significance of the disease, few truly integrated Ae. aegypti control programs exist, and most countries have very limited ability to conduct daily vector control activities. As a result, most countries respond to outbreaks and epidemics but pay little attention to routine prevention and control activities, including disease surveillance, Ae. aegypti surveillance, vector control, health communications and disease treatment. WHO enunciated its Global Strategy for the Prevention and Control of Dengue Fever in 1995. The political will required for implementing this strategy was made evident in 2002, when the 55th World Health Assembly adopted a Resolution on Dengue Fever and Dengue Haemorrhagic Fever Prevention and Control (WHA55.17). The Pan American Health Organization (PAHO) developed guidelines for integrated dengue control in 1995, and recently the member states of PAHO unanimously approved a Blueprint for Action for the Next Generation: Dengue Prevention and Control (PAHO/HCP/HCT/206/02). Given this context, it is timely to identify and share best practices for dengue prevention and control.

CONCLUSIONS: Integrated Ae. aegypti control is not only feasible, but is essential to address the myriad breeding sites found in the urban environment. The identification of best practices is particularly important given the PAHO recommendation that dengue prevention and control programs focus on increasing intersectoral collaboration and action. Best practices have been identified from various countries in Latin America, addressing disease surveillance (case definition, clinical diagnosis, laboratory diagnosis, case reporting), vector surveillance, vector control (for various types of containers and with several methods), advocacy, community participation, case management, training (for health facility staff, municipal government staff and children through formal school systems), emergency response and social communication/health education.

PARTNERS: USAID Environmental Health Project, USAID CHANGE Project, PAHO, Centers for Disease Control and Prevention

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E3
Malaria, Dengue, Cholera: Environmental Strategies for Control and Prevention

Moving Country Partnerships to Control Malaria

JOSEPHINE AKAKULUBELWA NYAMBE

LEARNING OBJECTIVES: Participants attending this session will be able to: organize a nationwide campaign to control disease; mount an effective multimedia campaign to increase awareness and involve partners; and move the health systems to work with partners to control diseases.

BACKGROUND: Malaria is endemic in Zambia, and is a leading cause of morbidity and mortality. It is the highest leading cause of outpatient attendance and hospital admission in all age groups. Malaria is especially dangerous to young children and pregnant women. Zambia is a member of the Roll Back Malaria global partnership initiative, whose main objective is to halve the burden of malaria in the country by the year 2010 through partnerships, increased awareness, effective case management, use of insecticide-treated mosquito nets (ITNs), presumptive treatment of pregnant women and monitoring and evaluation. To kick off the initiative, a number of partners and the Ministry of Health came together to implement a countrywide campaign aimed at improving implementation of malaria-reduction strategies. Activities planned included purchase and distribution of ITNs and re-treatment packs, a race against malaria through the country, Miss Roll Back Malaria contest, bungee jump, mounting of billboards in every district, production and distribution of posters and leaflets, TV discussion, radio quizzes, radio and TV spots, drama, community mobilization and community activities such as the sale of ITNs, vector control, and local chiefs purchasing ITNs and addressing their subjects. Donor agencies and private and public institutions pulled resources together and organized the events. The momentum was kept up by the TV and radio spots throughout the two weeks. The race attracted huge numbers of community members in each district they passed through; they distributed leaflets, unveiled billboards, sold nets, held public meetings and distributed re-treatment kits. The runners handed the torch to a local dignitary in each district, who ran some distance with it. The climax of the event was the crowning of Miss Roll Back Malaria, the bungee jump and an address by Senior Chief Mukunis.

CONCLUSIONS: Amazing coordination and collaboration was established between partners, both in human and financial resources. Districts commenced the sale of ITNs and heightened prevention activities. Public response was overwhelming; ITN sales went up so much that some districts were outstripped of ITN stocks. Pregnant mothers in some districts started to demand IPT.

PARTNERS: Ministry of Health, WHO, UNICEF, USAID, JAICA, World Vision

ADDITIONAL AUTHORS: Uttara Barath, Elizabeth Serlemitsos

ABSTRACTS

E4
Filling the Gaps: Measures for Better Understanding of Gender-Based Violence

Men, Gender Violence and Sexual and Reproductive Health: A Qualitative and Quantitative Study with Men Ages 15-60 in Rio de Janeiro

GARY BARKER

LEARNING OBJECTIVES: Participants attending this session will be able to understand the involvement of men in sexual and reproductive health issues and prevention of violence against women.

BACKGROUND: This presentation will present the results of a qualitative and quantitative study of men ages 15-60 years in three neighborhoods in Rio de Janeiro, two low income and one middle income, on gender violence and sexual and reproductive health. Focus group discussions confirmed numerous justifications that men used for violence against women, as well as identified differences between lower-income neighborhoods and the middle-income neighborhood in terms of violence against women.

METHODOLOGY AND RESULTS: A questionnaire was applied to 749 men, and focus group discussions were carried out with 52 men in the same neighborhoods. The study found that 25.4 percent of men said that they had used physical violence at least once against a female partner. Nearly 40 percent said that they had used psychological violence against a female partner at least once, including insults, humiliation or verbal threats. In total, 51.4 percent of men had used some kind of violence - physical, psychological or sexual - against a female partner at least once. Use of violence against women was associated with lower educational attainment and with having been a victim of violence or witnessed violence against women in family of origin. Men aged 20-24 years had the highest rates of self-reported use of combined violence (physical, psychological and sexual) against women. The two low-income communities had higher rates of self-reported violence than men from the middle-income community, although income was less associated with use of violence than was educational attainment. In terms of sexual and reproductive health, use of violence against women was associated with lower condom use with stable partners. Fifteen percent of all men reported having had a sexually transmitted infection (STI) at least once, but only 42 percent said that they informed their partner of this STI, arguably another form of gender violence. Forty percent of men had witnessed violence by a man against a woman in their home of origin and 45.5 percent reported having been victims of physical violence in their homes.

CONCLUSIONS: Results of the study are being used to enhance projects carried out by Instituto NOOS and Instituto PROMUNDO to work with men to promote greater involvement by men in sexual and reproductive health issues and to prevent violence against women, as well as interventions with men who have used violence against women.

ADDITIONAL AUTHOR: Marcos Nascimento

ABSTRACTS

E4
Filling the Gaps: Measures for Better Understanding of Gender-Based Violence

Gender-Based Violence Research in East Timor: Lessons Learned

MICHELLE HYNES

LEARNING OBJECTIVES: Participants attending this session will learn about issues and outcomes related to conducting a gender-based violence survey among a conflict-affected population in East Timor.

BACKGROUND: The Reproductive Health for Refugees Consortium, a group of seven international NGOs, has identified several gaps in describing and responding to gender-based violence in conflict-affected populations. Primary among those gaps are scant prevalence data and lack of best practices for quantitatively and qualitatively describing the problem of gender-based violence. Conflict and post-conflict prevalence of gender-based violence in East Timor is not known. Information is needed to inform prevention and care strategies.

METHODOLOGY AND RESULTS: In July and August 2002, the Centers for Disease Control and Prevention and the Reproductive Health for Refugees Consortium, in collaboration with the International Rescue Committee/East Timor, conducted a survey on gender-based violence (GBV) in two districts in East Timor of 288 women aged 18-49 years. GBV issues investigated in the survey were conflict/post-conflict rape and sexual assault, physical assault, reproductive health outcomes of violence, family/intimate partner violence and mental health. The presentation will review research methodology, present survey findings and highlight lessons learned. The presentation will also present outcomes of the research in terms of advocacy, programming and future research efforts. The methodology, findings, lessons learned, and programmatic and policy outcomes of the research will be compared to similar research conducted in Kosovo.

CONCLUSIONS: The survey results and lessons learned on methodology will inform a national GBV survey in East Timor, to be undertaken in fall 2002. The findings of the research will also guide future prevention and care strategies in East Timor.

PARTNERS: Centers for Disease Control and Prevention, International Rescue Committee/East Timor, Reproductive Health for Refugees Consortium

ADDITIONAL AUTHORS: Jeanne Ward, Kathryn Robertson, Victor Balaban

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E4
Filling the Gaps: Measures for Better Understanding of Gender-Based Violence

Measuring Gender-Equitable Norms: Validation of the Gem Scale

JULIE PULERWITZ

LEARNING OBJECTIVES: Participants attending this session will be able to: 1) understand the process of operationalizing indicators for gender-equitable norms, as well as the development and validation of a scale to measure gender norms; and 2) articulate the empirical relationship between gender norms, condom use and partner violence among young men in Brazil.

BACKGROUND: While there is increasing recognition of the influence of norms that support inequitable gender relations on HIV/sexually transmitted infection (STI) risk and partner violence, few empirical studies have explored these relationships using a validated measure for gender-equitable norms. This abstract presents the development and validation of a scale to measure gender-equitable norms among young men.

METHODOLOGY AND RESULTS: Gender-equitable norms and behaviors were operationalized based on focus group discussions and in-depth interviews with the study population. Scale items were then administered as part of a household community survey with a representative sample of men in low-income communities in Rio de Janeiro, Brazil. Scale analyses, including factor analyses and reliability tests, were conducted with young men aged 15-24 years (n=224). Construct validation was further explored through the relationship between the scale, and condom use and partner violence. The 24-item gender equitable men (GEM) scale possesses good internal reliability (coefficient alpha >0.80) and predictive validity. Factor analyses support two subscales: traditional gender norms – e.g., men are always ready to have sex - and egalitarian gender norms – e.g., a couple should decide together what type of contraceptive to use. As hypothesized, higher scores on the GEM scale were inversely associated with partner violence and directly associated with condom use ($P<0.05$).

CONCLUSIONS: The GEM scale appears to be a psychometrically sound measure for gender-equitable norms among young men. Study results provide empirical support for the notion that promoting gender-equitable norms would be important when attempting to influence HIV risk and partner violence.

ADDITIONAL AUTHORS: Gary Barker, Marcio Segundo

E5
The Baby's Environment: Improving Newborn Care

Cost and Effectiveness of Breastfeeding Interventions in Ghana

GRACE CHEE

LEARNING OBJECTIVES: Participants will: 1) learn about a set of tools used to measure the cost and effectiveness of breastfeeding interventions; 2) understand the costs associated with LINKAGES breastfeeding interventions in Ghana; and 3) describe the cost-effectiveness of breastfeeding interventions using two indicators: timely introduction of breastfeeding (TIBF) and exclusive breastfeeding (EB).

BACKGROUND: LINKAGES is a USAID-funded global program providing technical assistance to organizations promoting breastfeeding. It has been working in Ghana in this capacity since 1999. By focusing on community-level activities, LINKAGES has shown that it can successfully increase target breastfeeding behaviors in relatively short periods of time. Evaluation of its activities in October 2000 found that exclusive breastfeeding in the intervention communities was 68 percent, compared with 44 percent in control communities. In the program areas, 50 percent of infants were put to the breast within the first hour of birth, as opposed to 22 percent reported in the control communities. Going one step beyond measuring outcomes, this study analyzes the cost-effectiveness of LINKAGES' interventions in five districts using two measures of effectiveness: TIBF and EB.

METHODOLOGY AND RESULTS: This study includes total costs of the LINKAGES' Ghana interventions. Cost information is analyzed on two levels. First, the study calculates the cost-effectiveness of LINKAGES' inputs in these interventions, comparing outcome measures with LINKAGES costs only. The second level analysis includes the costs incurred by local partners to achieve the outcomes documented. LINKAGES' and its partner costs are analyzed by intervention region, by activity and by behavior change attained. All costs are fully allocated to activities, which are then allocated to district-level behavior change. Using this methodology, the study calculates the cost of attaining increases in each of the targeted behaviors. Cost data was collected at LINKAGES DC, LINKAGES Accra, at LINKAGES NGO partners and all levels of the Ministry of Health. The measure of effectiveness used is the additional number of children practicing appropriate EBF and TIBF. The data from the study districts show that the most cost-effective interventions are in districts with lower EBF and TIBF rates, relatively larger populations and where there are active community partners. Districts that incurred higher costs generally achieved better outcomes. Based on this study, the costs of replicating this set of activities in other districts in Ghana is estimated to be $16 per child. Costs of replication may be lower in districts with higher target population and lower EBF and TIBF rates. Considering implementation costs only, for comparison with other studies, shows that the cost-effectiveness of LINKAGES' interventions in Ghana is in line with other breastfeeding promotion interventions.

CONCLUSIONS: LINKAGES' interventions in Ghana are cost-effective, based on the limited data available from other studies. LINKAGES may be able to increase its cost-effectiveness through selection of more active community partners, and districts with higher population and lower rates of EBF and TIBF.

PARTNERS: USAID-funded LINKAGES project, Ghana Ministry of Health

ADDITIONAL AUTHORS: Marty Makinen, Bryn Sakagawa, Nadra Franklin, Vicky Quinn, Joan Schubert, Rosanna Agble

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E5
The Baby's Environment: Improving Newborn Care

Cultural/Behavioral Research in a Neonatal Care Campaign: Egypt

MARWA KAMEL

LEARNING OBJECTIVES: Participants will be able to describe at least three culturally patterned issues in neonatal care and to explain the use of qualitative research for communication campaigns, including a new data analysis tool.

BACKGROUND: Often it is difficult to know when to conduct research and how to utilize the results. The USAID-supported Egypt Healthy Mother/Healthy Child Project (HM/HC) aims to reduce maternal, infant and child mortality. Newborn care is a project priority. HM/HC provides an example demonstrating the role of qualitative research to illuminate quantitative results, reveal additional information and inform design of communication campaigns. It also introduces a new qualitative data analysis tool. A project KAP (knowledge, attitude and practice) survey of postpartum and newborn care in Upper Egypt found that women did not recognize or seek care for most newborn illnesses in the first week of life. HM/HC commissioned a qualitative study and separate data analysis to elucidate the findings and inform development of a campaign promoting healthful newborn and postpartum care. The qualitative study included individual in-depth interviews or focus group discussions with 38 community leaders, 86 recently delivered mothers and the mothers' mothers-in-law, husbands and birth attendants (n=56). The sample was drawn from selected rural and urban areas of three Upper Egyptian governorates. A new qualitative data analysis tool, geared to how data would be used programmatically, highlighted relationships between practices, cultural meaning and program implications. Results were entered easily into a strategy matrix and incorporated into campaign and message design, and the brief for the advertising firm.

CONCLUSIONS: Qualitative study results clarified and added to earlier quantitative results. The tool and strategy matrix greatly facilitated data analysis and campaign development. Analysis indicated sub-optimal cord care by providers, potentially harmful treatments of newborns' eyes by midwives and family members, and fears of supernatural harm to babies seen by strangers before the 40th day of life. The campaign ran during 2001. It emphasized cord care, care of newborns' eyes, recognizing danger signs in newborns and taking the baby to a health facility during the first weeks of life.

PARTNERS: HM/HC staff, SPAAC, Dr. Salma Galal, Manoff Group staff, Promoseven

E5
The Baby's Environment: Improving Newborn Care

Delivery and Newborn Care in Pakistan: Practices and Communication

OMRANA PASHA

LEARNING OBJECTIVES: Participants attending this session will be able to identify common antenatal, delivery and newborn care practices in rural Pakistan, and the role of key decision-makers in these behaviors.

BACKGROUND: Neonatal mortality accounts for half (40-60 percent) of all infant mortality in Pakistan. Estimates of the perinatal mortality rate in Pakistan range from 54 to 82 per 1,000 births. Neonatal death is related to home delivery not attended by trained personnel, short birth interval and maternal/paternal illiteracy. However, it is not known how decisions relating to these practices are made. A study explored the perspectives of mothers, fathers and paternal grandmothers of children one year old or less on decision-making and practices for antenatal, natal, postnatal and neonatal care.

METHODOLOGY AND RESULTS: The study identified all of the households with a child younger than one year or a woman who had been pregnant in the nine months prior to the survey in two randomly selected villages in Haripur district. All of the mothers were interviewed using standardized questionnaires. The questionnaires were designed to gather sociodemographic data, reproductive history, information on care-seeking practices during pregnancy, delivery and the neonatal period for both mother and child, knowledge of danger signs, decision-making and intra-familial communication. Eighty-four eligible households were identified and all of the mothers were interviewed. Eleven (13 percent) of the 84 women reported at least one stillbirth, 16 (19 percent) reported at least one death of a live-born child and 20 (24 percent) reported a miscarriage in their lifetime. Few women had appropriate care during their pregnancies: 50 percent sought antenatal care from trained personnel; 56 percent had received tetanus toxoid; only one-third (35 percent) reported that their families made any preparations for the delivery and few (16 percent) sought postnatal care. Most of the neonates (77 percent) were born at home and delivered by traditional birth attendants (70 percent) who cut the umbilical cord with a household utensil (70 percent) and applied clarified butter to the stump (55 percent). Very few of the newborns were placed with their mothers after birth (4 percent); in fact, most of them (80 percent) were bathed immediately. Although breastfeeding was the norm (96 percent), few children received colostrum (33 percent) and most were given pre-lacteal feeds (88 percent). Only 26 percent of the mothers knew any of the danger signs for which to seek care for their child in the immediate postpartum period, and few of the infants were ever seen by a health provider (32 percent) at all. Almost half (49 percent) of the mothers believed that if the newborn did not breathe immediately after birth, then nothing could be done because he/she was already dead. The majority of women did discuss pregnancy-related issues with their husbands (66 percent) and their mothers-in-law (62 percent) during their pregnancy.

CONCLUSIONS: Newborn care practices in these villages are poor and may underlie much of the neonatal mortality seen. Few newborns receive the benefit of trained delivery or perinatal care, and household practices (such as kangaroo care or immediate and exclusive breastfeeding) that could improve newborn outcome are rarely practiced. Maternal knowledge of newborn health is also poor. Few mothers seek appropriate care for themselves during pregnancy. One encouraging thing that was noted is the relatively high level of intrafamilial communication about pregnancy and newborn care. Thus, any intervention directed at newborn care will be able to involve all of the key decision-makers in the shouseholds.

ADDITIONAL AUTHORS: Mohammad Shafique, Ajeeba Khatoon, Ambreen Amama, David Marsh

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E6
Research to Policy: Models that Work for Improving Health and the Environment

Research, Policy and Governance: Exploring the Connections

LAWRENCE HADDAD

LEARNING OBJECTIVES: Participants will understand the distinction between ensuring that research-based findings are accessible and well considered in decision-making versus advocating for specific policy choices. Participants will understand how to incorporate this distinction in the design of research and how to guide the use of research in policy development.

BACKGROUND: The notion that scientific research should guide public policy is widely accepted by researchers, their institutions and society at large. However, there is an important distinction between ensuring that research-based findings are accessible and well considered in decision-making versus advocating for specific policy choices. This distinction often is not well recognized and respected in the design and composition of expert or advisory committees and in the giving and receiving of expert opinion by individual researchers.

CONCLUSIONS: An increasing body of academic thought as well as influential bodies such as the National Research Council in the United States have recommended significant changes in how scientific knowledge is used in policy formulation. These changes pose challenges to the conventional practices of many research institutions, as well as opportunities for them to experiment with and evaluate improved approaches for policy development. This presentation will provide examples of some of these innovative practices and describe the efforts of one research organization, the International Food Policy Research Institute, to re-orient the ways in which it initiates and undertakes research and the other roles it plays in the policy process.

ADDITIONAL AUTHOR: David Pelletier

E6
Research to Policy: Models that Work for Improving Health and the Environment

Policy Applications of Ecosystem Approaches to Human Health

JEAN LEBEL

LEARNING OBJECTIVES: The participants attending this session will be exposed to some concrete examples of research in human health and environment that are successfully translated into policy and practice. They will be able to recognize Ecohealth as a unique approach to human health that uses ecological approaches to view humans as an integral part of the environment.

BACKGROUND: Issues are how to conduct research with a broad concept of disease prevention and health promotion, and to apply it globally to programs and policy. Regional projects have different emphases in the physical environment: water quality and management in the Middle East; tropical diseases in Central America; and urban agriculture and rural development in West Africa. The conditions in each region demonstrate locally relevant approaches to applying research to policy.

CONCLUSIONS: Urban and rural health problems must be dealt with in a manner that goes beyond a medical approach. Research must be developed in a multistakeholder approach.

PARTNERS: WHO, UNEP, UN Foundation

ABSTRACTS

E6
Research to Policy: Models that Work for Improving Health and the Environment

Bridging Research and Policy in Health and the Environment

NATALIA DINELLO

LEARNING OBJECTIVES: The participants attending this session will be able to recognize challenges in mainstreaming research results into policies and programs of decision-makers. They will hear about mechanisms that would best ensure a 'market' among policy-makers for research output.

BACKGROUND: Issues are how to improve research-policy links and impact in health and environment, and to improve policy development and implementation in developed and developing countries to reduce poverty. The project, sponsored by the Global Development Network, has the following components: 1) establish a community of policy-makers, researchers and communicators to discuss themes and synthesize lessons into useful recommendations and practical tools for policy-makers and researchers; 2) undertake surveys to provide a quantitative foundation to research on development; 3) collect case study experience where research has or has not contributed to policy; and 4) host the RAPNet research and policy knowledge website. The project is funding specific research studies to explore in-depth the issues that arise from initial analysis.

CONCLUSIONS: Case studies analyzed thus far reveal that while the political contexts are important to bridging research and policy, these contexts can change quickly, requiring policy-oriented research to be adaptable. Participation of policy-makers in research design is a key issue. Advocacy efforts have to be strong to influence policy. There exists a need for continuous feedback loops between research, policy, implementation and monitoring. Specific application to health and environment policies will be discussed.

PARTNERS: The Global Development Network, UNDP, the World Bank, several publicly backed institutions from Germany, the United States and Japan

ADDITIONAL AUTHORS: Leena Srivastava, Lyn Squire, John Young

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ABSTRACTS

F2
Our Children, Our Future: Reaching Children Affected by AIDS

Meeting the Growing Challenge of Africa's AIDS Orphans

MILTON B. AMAYUN

LEARNING OBJECTIVES: Participants will be able to describe three innovative and replicable approaches meeting the health and development needs of orphans and vulnerable children in sub-Saharan Africa.

BACKGROUND: Over the last decade, the HIV/AIDS pandemic significantly altered the health status and socioeconomic environments of several African countries, dimming their hopes of escaping the poverty trap. Gains in child survival have been reversed. A cohort of adults has died, leaving grandparents in charge of rearing young orphans. Demands on health systems are increasing. Diminished food production has worsened food insecurity. The staggering reality is that HIV prevalence is still rising in most high-prevalence countries of sub-Saharan Africa. These trends on orphans and vulnerable children (OVC) are projected to worsen within this decade. Today's 14 million orphans will rise to 40 million by 2010. More than 90 percent of these children will come from 19 countries of sub-Saharan Africa, many of them among the least developed. Until antiretrovirals are made universally available, the numbers of HIV-positive infants will continue to rise. In response to the above, World Vision (WV) launched the HOPE Initiative to help reduce the global impact of HIV/AIDS. Its key strategies are the reduction of HIV transmission, the improvement of the quality of life of OVCs and their families, and advocacy for public policy decisions to support prevention and care interventions. As a child-focused international NGO, WV is committed to implementing technically up-to-date, holistic, community-based approaches to OVC care that are replicable, impact-oriented, and able to be scaled up. With its faith-based orientation, WV is also mobilizing churches in North America and Africa to become linked in a long-term collaborative effort to provide the resources needed to save a generation of children. Social laboratories called 'Models of Learning' have been established in Uganda and Zambia to identify best practices in OVC programming and resource mobilization.

CONCLUSIONS: Although the HIV/AIDS crisis must be considered an urgent challenge for all sub-Saharan countries, approaches to the care of OVCs must be developmental, long-term and holistic. These approaches from the Models of Learning in Zambia and Uganda that have the potential to be scaled up within and across countries are: 1) child sponsorships that ensure minimum basic needs and primary education; 2) re-orientation of community development programs to include HIV/AIDS and OVCs as an inseparable development focus; 3) deployment of trained 'guardian angels' to follow up child-headed households; 4) complementary matching of local and external resources over several years; 5) partnerships with faith communities and grassroots organizations to ensure sustainability; 6) ongoing communication and advocacy to sustain public awareness and commitment; and 7) linking HIV/AIDS prevention with other development themes: gender, justice, poverty, and human transformation.

ADDITIONAL AUTHORS: Mark Lorey, Hector Jalipa

F2
Our Children, Our Future: Reaching Children Affected by AIDS

Community-Based Strategies for Sustainable Projects Improving the Quality of Life of AIDS Orphans

PRISCA N. NEMAPARE

LEARNING OBJECTIVES: Participants will understand the desperate circumstances and identify the primary near-term and midterm needs facing AIDS orphans and their caregivers, the development and implementation of successful income-generating projects, and the link between these income-generating projects and the efforts of the Zienzele Foundation (ZF) to keep these orphans in primary and secondary school. Participants will be able to adapt the fundamental organizational structures to other similar circumstances worldwide.

BACKGROUND: HIV/AIDS results in 5,000 deaths per week in Zimbabwe. The demographics produce an expanding population of orphans who lack one or both parents. The care of these orphans by an aging population of caregivers produces unique challenges to this new type of 'family' unit. Increased food requirements in the face of drought, school fees and clothing needs require an income stream heretofore unavailable. Income-generating projects were developed in the Gwanda and Masvingo Provinces of Zimbabwe. Projects include making native baskets for market sale, raising chickens and selling eggs as an income and protein source, and planting sustainable community gardens as a primary food source. The chicken and garden projects provide immediate nutritional assistance to the communities. ZF purchases the native baskets from the basketmaking groups. These groups allocate income to their members and re-supply them, thereby continuing the basketmaking process. ZF in turn sells these baskets in the United States. The proceeds are utilized by the ZF to pay school fees for AIDS orphans (480 to date). Project development in each village involves several important steps. Initially, meetings with community leaders, school administrators, councilors and various agricultural experts are held to explain program objectives and development guidelines. Assessments of needs and available resources are followed by meetings with the orphan caregivers. These caregiver meetings result in identification of group needs, a project proposal to meet these needs, a constitution, an election of committee members, a budget plan and a contract agreement with ZF. ZF reviews the proposals for sustainability and subsequently conducts surveys and home visits with all children enrolled in the program.

CONCLUSIONS: Small community-based projects successfully address the challenges faced by AIDS orphans and their caregivers by producing a means to generate income and support the nutritional needs of individual families. Projects producing marketable products outside the region can have additional benefits when a sufficient infrastructure exists to bring these products to lucrative markets. ZF has marketed these products and directed the proceeds toward the payment of school fees for the community's AIDS orphan population.

PARTNERS: Earthwatch Institute, Ministry of Health and Child Welfare – Masvingo and Matabeleland Provinces

ADDITIONAL AUTHORS: Nancy P. Clark, James H. Clark

F2
Our Children, Our Future: Reaching Children Affected by AIDS

Reducing High-Risk Behavior of Street Children in Delhi

E.K. VINAYAKAN

LEARNING OBJECTIVES: Participants attending this session will be able to understand the environmental conditions, both social and physical, that increase children's risk for contracting HIV/AIDS, and learn about elements of a program that systematically addresses these environmental risks.

BACKGROUND: Living conditions on the streets of New Delhi, India itself is a situation that increases children's risk for contracting HIV/AIDS. Project Concern International (PCI) intervenes through drop-in centers that are located in the vicinity of railway stations, bus stops and slum settlements, where street and rag-picking children gather. These children are provided with education, entertainment, regular health check-ups, counseling, recreation, microsavings programs and vocational training. Regular awareness campaigns are organized through street theatre performed by trained street children, distribution of handbills and posters, and talks with the community on prevention of HIV/AIDS and sexually transmitted infections (STIs). A separate health file folder is maintained for each and every child attending these centers. This helps lead to constant follow up and monitoring of improvements in STIs and increases in the knowledge of the children. PCI has developed a successful strategy of disseminating information through peer educators. PCI provides vocational training to the children and peer educators, and finds suitable placements through its apprenticeship program. The impact of the program on children is measured through a child development measurement tool. 'Children Affected By AIDS' is one of the PCI projects, which was started in March 2000 for 1,400 street and working children. After 18 months, the project was evaluated by Family Health International/India. Results show that almost 97 percent of the peer educators know that HIV/AIDS could be prevented and 79 percent of the peer educators understand that consistent use of condoms would reduce the risk of HIV infection. About 50 percent of the peer educators are also aware of the risk of transmission through infected blood transfusion. About 49 percent of peer educators are aware of the risk involved in multiple partner sex, either male or female.

CONCLUSIONS: Using a comprehensive and peer-oriented approach to addressing environmental factors, there can be a remarkable increase in the knowledge of peer educators and the children they reach on HIV/AIDS and STIs.

PARTNERS: Street children

ADDITIONAL AUTHOR: Anil Verma

ABSTRACTS

F3
Continuum of Care: Essential Pregnancy-Related Services

Taking Post-abortion Care to Scale Despite Formidable Conservatism

PAMELA BOLTON

LEARNING OBJECTIVES: Participants will be able to explain strategies for rapid extension of post-abortion care services in a conservative Muslim context.

BACKGROUND: Niger has a deeply traditional Muslim culture and among the world's most restrictive abortion laws. Yet in this unlikely environment, post-abortion care (PAC) advanced from a single-site pilot introduction to a national scale-up phase in 12 months. We review the opportunities and strategies that 'PAC pioneers' in Niger capitalized on to surmount potential obstacles in the pilot phase and move to a national expansion phase.

METHODOLOGY AND RESULTS: During the 12-month pilot phase in Gazobi Reference Maternity, Family Care International trained doctors and midwives in best practices for management of abortion complications, strengthened counseling skills, improved infection prevention practices and established a family planning unit within the hospital. Extension phase activities include: 1) official approval of the national expansion plan and recognition that PAC saves lives and contributes to safe motherhood; 2) assessments to identify specific gaps and needs in four expansion sites; 3) across-the-board infection prevention training and other training in response to site needs; 4) preparation by the PAC nucleus team of financing requests for in-country donors, laying the groundwork for sustainability; and 5) development of a national cadre of PAC trainers/supervisors. Several strategies have proven critical to advancing PAC in the Niger context: 1) strong emphasis on situating PAC as an integral component of safe motherhood and emergency obstetric care (both are key Niger Ministry of Health priorities); 2) careful advocacy to show how PAC is consistent with Islamic principles; 3) South-to-South cooperation training, technical assistance and role-modeling from Burkina Faso; 4) strategic 'leverage' of participation at a regional conference on PAC in Francophone Africa (March 2002); and 5) involvement of the regional reproductive health research network and promotion of friendly competition.

CONCLUSIONS: Situating PAC as an integral component of safe motherhood, careful advocacy to show how PAC is consistent with Islamic principles, and capitalizing on the experience of 'kindred' countries can help advance PAC in conservative environments.

PARTNERS: Issaka Gazobi Maternity, Ministry of Health, Niger, Celule de Recherche en Santé Reproductive (CRESAR)/Niger, Family Care International

ADDITIONAL AUTHORS: Haoua Afagnibo Diallo, Madi Nayama, Madeleine Garba, Arziki Souley

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F3
Continuum of Care: Essential Pregnancy-Related Services

The Skilled Attendant: Essential Competencies and Responsibilities

PATRICIA P. GOMEZ

LEARNING OBJECTIVES: At the end of this session, the learner will be able to: discuss the critical importance of skilled providers to saving the lives of women and newborns; define the term 'skilled provider'; and list three competencies and responsibilities used by skilled providers to create an environment of effective care for mothers and newborns.

BACKGROUND: Skilled care is a system of services that function together to provide essential care to women and newborns from pregnancy through the postpartum/newborn periods. A skilled provider is a health-care provider with the knowledge, skills and qualifications necessary to deliver essential maternal and newborn care, whether in the home or a health facility. The approaches being used by the maternal and neonatal health program and the FCI's Skilled Care Initiative feature a training pathway that enables providers to attain a set of 'core competencies' as well as learn 'core responsibilities' to care effectively for mothers and babies during the antenatal, childbirth, postpartum and newborn periods. The core competencies are evidence-based, globally accepted practices that can be used in low-resource settings to prevent, identify and treat diseases and complications that contribute to maternal and newborn morbidity and mortality. Examples of these competencies include the practice of focused antenatal care, active management of the third stage of labor, and early and exclusive breastfeeding. The skilled provider must also assume the core responsibilities of establishing and maintaining effective health-care services that are in accordance with national policies, and advocate for linkages among key stakeholders in the care provision system.

CONCLUSIONS: Experience has shown that resources invested to develop training sites, update providers' knowledge and skills, and train them as clinical and advanced trainers with problem-solving capabilities facilitates the sustained production of providers who will care for pregnant women and their babies using appropriate technology and globally accepted standards of care. These same providers have established linkages with the communities where they work, broadening the base of support for pregnant women to tap into when they need funds, transport and specialized medical care in the face of complications. Simple adaptations of this 'core competency' and 'core responsibility' strategy will make it useful in many settings, increasing access to safe motherhood for women throughout the world.

PARTNERS: JHU/CCP, PATH, CEDPA, CHANGE Project, EngenderHealth, PHRPlus, Blancroft Research International

ADDITIONAL AUTHORS: Johnmark Opondo, Harshad Sanghvi, Barbara Kinzie, Ellen Themmen, Annie Thairu

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F3
Continuum of Care: Essential Pregnancy-Related Services

Availability of Emergency Obstetric Care in Morocco

MOSTAFA TYANE

LEARNING OBJECTIVES: Participants will be able to describe the UN process indicators for assessing adequacy of availability of emergency obstetric care services, and Morocco's efforts to provide these services to women nationally.

BACKGROUND: The UN process indicators for monitoring obstetric services for the prevention of maternal mortality answer several questions pertaining to the availability and utilization of life-saving services, beginning with the question 'Are there sufficient facilities providing emergency obstetric care (EmOC)?' The UN process indicators are used both in needs assessments and to monitor ongoing provision of services.

METHODOLOGY AND RESULTS: The UN process indicators were used in a national needs assessment undertaken in Morocco from 2000 to 2002 that included 510 government maternities and birthing centers. Morocco has a population of over 30 million people. The needs assessment was undertaken by the Ministry of Health, Department of Population and UNFPA over a period of 22 months, and covers services delivered in the calendar year 2000. For a country of its size, Morocco should have at least 60 comprehensive facilities (one facility per 500,000 population), defined as facilities that provide all eight of the life-saving functions (called signal functions). According to the needs assessment, 61 hospital maternities are fully functioning as comprehensive emergency obstetric facilities. The UN process indicators specify that 240 facilities should provide six of the eight signal functions (four facilities per 500,000 population). Morocco has 137 such facilities, or approximately 60 percent of the recommendation for basic emergency obstetric facilities. Rural regions, especially in the south of the country, tend to be less well served compared with the more urban and developed areas to the north of the country.

CONCLUSIONS: Morocco is an example of a middle-income nation, with a maternal mortality ratio of approximately 390 maternal deaths per 100,000 live births and that is well advanced in the goal of making emergency obstetric care available to all pregnant women. Government commitment to women's reproductive health and specific policies aimed at improving access for underserved populations plays a major role in the progress made to date.

PARTNERS: UNFPA, the AMDD Program of Columbia University

LEARNING OBJECTIVES: Participants will learn about key steps to motivate commercial firms to participate in a public health cause, and a unique approach to sustain the partnerships on a long-term basis.

BACKGROUND: The Program for Advancement of Commercial Technology, Child and Reproductive Health is a USAID-funded program of Icici Bank, a leading financial institution in India. The program is designed to expand access to quality reproductive and child health products and services through the private sector. Commercial Market Strategies (CMS)/India provided the technical advisors to the project to increase access to and the use of WHO oral rehydration solution (ORS) formulations in North India. CMS first approached the manufacturers as a group, presenting the highlights of the campaign and the benefits of becoming a partner. CMS then went individually to each of the partners and explained how the campaign implementation will work for their respective brands and the category. Of the nine manufacturers invited to the group meeting, six signed a formal memorandum of understanding. The partners agreed to implement a marketing plan to: 1) promote their brand as the first product to providers through the season; 2) distribute generic and brand-specific promotional materials; 3) call on and inform at least 8,000 doctors each about the campaign and their brands; 4) use the campaign logo on the promotional materials as well as sample and sales packs; and 5) provide samples to the CMS field force who would call on an additional 55,000 pharmacists and traditional doctors for informing, demonstration and sampling purposes. The partner manufacturers provided a total of 100,000 units of samples for the diarrhea season from April to September 2002.

CONCLUSION: The collective efforts of the CMS field force and the six partner manufacturers paid rich dividends in 2002. From January to August, sales in the ORS category grew by 19 percent while sales of WHO ORS brands grew by 45 percent over the same period last year. This represents a change in volume from 15.4 million to 18.4 million liter units. Working together to expand the market as a whole and individually with each partner at both managerial and field levels has led to their continued commitment to the project.

PARTNERS: Icici Bank, Merck, Wallace Pharma, FDC Pharma, TTK Healthcare, Shreyas Healthcare, CFL Pharma

ADDITIONAL AUTHOR: Rita Leavell

F4
Public-Private Partnerships: Resource Mobilization for Health Care

Creating and Sustaining Partnerships with Commercial Firms

V.G. KRISHNAN

ABSTRACTS

LEARNING OBJECTIVES: Participants will understand that market financing is the largest sustainable pool of financial resources to fund environmental improvements that reduce industrial threats to health. Participants will also understand how to develop a program to tap those resources.

BACKGROUND: The transition countries of Central and Eastern Europe and the former Soviet Union face costly health burdens and obstacles to growth because of pervasive environmental mismanagement and contamination that is a legacy of the Soviet era. The USAID-funded Environmental Action Programme Support (EAPS) project worked in eight countries to identify environmental projects, develop and package them for financing, and build a base of ongoing finance for industrial improvements. EAPS did everything from promoting awareness of funding sources to strengthening the regulatory environment to build demand for cleaner processes and strengthening lending capability. Ultimately, EAPS helped obtain financing for 150 environmental investments, leveraging USAID's investment at a ratio of 1:62; that is, every dollar USAID spent through EAPS to mobilize investment leveraged $62 of investment from other sources. Participating enterprises reduced heavy pollution by investing in more efficient equipment or introducing cleaner fuels. This significantly reduced threats to human health by reducing emissions and by addressing occupational health and safety issues. For example, improvements in one plant in Russia were estimated to reduce worker health costs by more than $1 million. EAPS recognized that, in the long run, only a robust continuing dynamic of capital mobilization will guarantee continued environmental investments. National Environment Funds were the source of much initial financing. EAPS worked to move Environment Funds gradually from grants, to loans, to loan guarantees and interest-rate subsidies involving commercial banks, to minority partners in financing packages. The objective was to establish a healthy commercial environmental financing dynamic that would eliminate (or at least greatly diminish) the need for a non-market mechanism such as the Environment Fund.

CONCLUSIONS: To cover the cost of industrial environmental improvement, focus should be primarily on creating a dynamic of demand and supply for sound environmental investments: a demand for financing for good environmental projects and a supply of capital to make those projects happen. It is necessary to rely on the private sector to finance environmental improvements. All the donor help imaginable will be insufficient to meet the demand for environmental financing, and may even be counterproductive if it undermines the private capital market. Heavily subsidized or free sources of environmental funds should be interim means for environmental finance and tools for fostering a commercial environmental capital market rather than permanent mechanisms for financing environmental investments.

ADDITIONAL AUTHORS: Avrom Bendavid, Chris Smith

F4
Public-Private Partnerships: Resource Mobilization for Health Care

Tapping Market Financing to Reduce Threats to Health from Industrial Pollution

HENRY KONER

F4
Public-Private Partnerships: Resource Mobilization for Health Care

Public-Private Sector Funding for Health Care in Nigeria

DAVID SHEAR

LEARNING OBJECTIVES: Participants will be able to understand how to mobilize resources from multiple sources to address primary health care at the community level.

BACKGROUND: Citizens International (CI) and its partner organization, the New Nigeria Foundation (NNF), initiated the Community Health Services Program (CHSP) in the nine states of the Niger Delta Region, Nigeria in February 2001 and has expanded to Bauchi, Gombe and Niger States in the North. The overall goal of CHSP is to improve the health status of populations in targeted communities on a sustainable basis. CHSP seeks to improve local governance on health-related issues and to strengthen linkages between remote rural health clinics and their supporting secondary health facilities. To accomplish these objectives, CI and NNF have facilitated the establishment of community health committees (CHCs) at each CHSP site. CHCs are democratically elected bodies chosen by their communities to implement CHSP activities and to serve as the liaison with state and local government authorities on public health matters. Recognizing that different communities may have different health needs, CI and NNF have adopted a participatory approach to identify and prioritize the needs of each CHSP community. CHSP is expected to expand its coverage to 300,000 beneficiaries over the course of its first full year.

CONCLUSIONS: This public-private sector approach creates a sustainable framework for mobilizing substantial resources from multiple sources that can be utilized to address grassroots primary health care needs rapidly and at low cost while increasing the capacity of local communities to manage many of their own primary health care needs. The public-private sector partnering also encourages corporations to contribute to development activities with a social conscience, in a manner that engages the community as partners and not as recipients only.

PARTNERS: United Nations Foundation, UNDP, the Bill & Melinda Gates Foundation, the David and Lucille Packard Foundation, ExxonMobil, several Nigerian state governments, UNICEF, WHO, Nigerian NGOs, local community governments

ADDITIONAL AUTHOR: Leslie Fox

F5
Defining Population-Environment Linkages and Institutionalizing Response

Influencing Environmental Health Policy: Experiences from the South

ROGER-MARK DE SOUZA

LEARNING OBJECTIVES: Participants attending this session will be able to describe mechanisms for advancing the policy agenda on environmental health issues; to understand how information enters and influences the policy process; and to explain how environmental health issues are perceived within a larger context of population-environment linkages.

BACKGROUND: Many scientific groups and environmental scientists agree that aspects of a population's growth, composition and distribution can lead to environmental changes that affect the human and ecosystem health. Advocacy efforts prior to and during various international conferences have placed many environmental health issues on the global agenda in the context of population and environment linkages. There is a long way to go, however, in setting priorities for environmental health issues within national political structures. Relying on policy communications research and case studies from Central America and the Philippines, this paper illustrates the factors that have helped advance environmental health concerns at the global policy level and examines how these factors may be replicated at the national and regional levels. The paper concludes with recommendations for prioritizing these issues within the political systems of developing nations over the next decade.

CONCLUSIONS: In the last four decades, concerns regarding population-environment linkages focused on limited natural resources, the generation of harmful chemical by-products, human-dominated ecosystems and the proliferation of newly emerging diseases. These changing concerns have spurred a growing recognition in policy circles that these linkages reflect a reciprocal relationship between humans and the environment, an unprecedented human impact on the environment and greater global interdependence. A series of factors help these issues gain prominence in national and regional agendas. They include trends and indicators that show the importance of the problems, champions and coalitions that advocate for these issues, key events that focus attention on environmental health issues, and feasible policy and programmatic alternatives.

PARTNERS: World Conservation Union (IUCN)-Mesoamerica, Save The Children/Philippines

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F5

Defining Population-Environment Linkages and Institutionalizing Response

Organizational Action for Responding to Population-Environment Linkages

CLARE GINGER

LEARNING OBJECTIVES: Participants attending this session will have an increased understanding of how action in NGOs influences definition, responses and measures of success in the arena of population-environment linkages, focusing on reproductive health and biodiversity conservation goals.

BACKGROUND: Defining and responding to linkages between population, health and the environment has been an ongoing focus for academics and practitioners concerned about population dynamics, reproductive health and environmental conservation. These linkages have associated with them problems of limited access to reproductive health services, unsustainable land use practices and loss of biodiversity. Given the range and intertwined nature of these problems, cooperation within and between organizations with varied expertise and goals is required for effective responses. However, definition of linkages, problems and responses are likely to vary between such organizations. Variation can be expected to influence capacity of organizations to act to help improve reproductive health and environment conditions. Several family planning, conservation and development NGOs have been working to define population-environment (PE) linkages and to develop integrated interventions with goals of increasing delivery of reproductive health services while attending to issues of land use and biodiversity. This study compares five cases (in Central America, South America, sub-Saharan Africa and Southeast Asia) in which organizations have been working to define and respond to PE linkages. It focuses on the organizational dimensions of these activities and considers the potential for future action and measures of success in the PE arena.

METHODOLOGY AND RESULTS: Data were gathered in cooperation with NGOs as well as the Population-Environment Fellows Program at the University of Michigan and include documents, interviews with NGO personnel and PE fellows, and observations during site visits. Analysis of the data and results focus on: 1) definitions of population, environment and linkages between the two; 2) organizational structure/processes of the NGOs and how these affect definition of linkages; 3) the role of organization mission and goals in defining cause-effect logics and how these affect decisions to act as well as expectations for defining success; 4) whether and how projects have been deemed successful in meeting reproductive health and biodiversity conservation goals; and 5) whether and how integrative initiatives can be translated into enduring processes and/or structures in the NGOs.

CONCLUSIONS: The study provides insight into how PE projects are defined with respect to problem solving, funding realities and emerging ideas about the nexus of population and environment inside varied organizational environments. It identifies factors important for building capacity for organizational action and considers future prospects for work in this area.

PARTNERS: Population-Environment Fellows Program, The Nature Conservancy, Conservation International

ABSTRACTS

F5

Defining Population-Environment Linkages and Institutionalizing Response

Achieving Integrated Population-Environment Programs in Biodiversity Hotspots

JAMES D. NATIONS

LEARNING OBJECTIVES: Participants attending this session will be able to describe successful methodologies for blending reproductive health components into on-the-ground biodiversity conservation projects in tropical, developing countries.

BACKGROUND: The regions of the earth undergoing the most rapid environmental degradation are the same regions experiencing the most rapid growth in human population. Conservationists have come to realize that if we fail to address the issue of human population growth in and around the protected areas where we work, we are wasting our energy and our donors' support.

METHODOLOGY AND RESULTS: To address these challenges, Conservation International, since 1998, has been adding reproductive health components to field projects in the biodiversity hotspots. We have established reproductive health projects inside conservation programs in Mexico, Guatemala and Madagascar, and during 2002-2003 will add programs in the Philippines and Southern Africa. This presentation reports on the successes and challenges of achieving project goals in these specific countries, with advice for teams attempting similar work in other regions.

CONCLUSIONS: Despite initial worries on the part of some field staff that working in reproductive health might harm our conservation efforts, we have seen that the rural families we work with are enthusiastic about having voluntary access to these health-care services. Moreover, our conservation work has improved because our relationships with these communities are reinforced by the new trust that population-environment programs have created.

PARTNERS: Mexfam, Ministerio De Salud (Mexico); Ministerio De Salud, Aprofam (Guatemala); Matesa (Madagascar)

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F6
Managing Injection Waste: Experience from the Field

Injection Waste Management Approaches in Senegal and Guinea

JULES MILLOGO

LEARNING OBJECTIVES: By the end of the session, participants will be able to: describe injection waste disposal practices in Senegal and Guinea; explain how collaboration among partners increased awareness about injection safety, including waste disposal in Senegal and Guinea; describe how increased incineration capacity was implemented in Senegal; and discuss how the Ministry of Health in Guinea developed policy for safe injection and waste disposal.

BACKGROUND: Safe injection and waste disposal challenge all health systems in developing countries. Targeted funding for health services along with increased awareness of local populations about unsafe injection practices and waste disposal resulted in pressure on Ministries of Health to improve safe injection and waste disposal practices in West Africa. Partners of the measles initiative, multisectoral AIDS control program and Global Alliance on Vaccines and Immunizations (GAVI) require safe injection and disposal plans in country proposals submitted for World Bank or GAVI funding. The government of Senegal conducted a mass vaccination campaign against measles for children aged 9 months to 15 years in December 2002. There was a general disbelief that injection waste disposal was a problem. However, data on disposal methods indicated that only about 10 percent of facilities had incineration capacity for health-care waste. The interagency coordinating committee therefore decided to construct additional incinerators in 50 districts. This reactive approach to increases in demand for injection waste disposal may meet an immediate need, but without capacity-building for the safe and effective operation and regular maintenance of incinerators, appropriate use and life span of the devices is likely to be poor. Guinea took a different approach to addressing safe injection and waste disposal needs by developing a national-level policy and action plan. This approach to planning allowed health systems managers to describe their situation, needs and challenges. A methodical plan was subsequently developed allowing health policy-makers to see where they are going. The plan also provides a guide for peripheral health services managers in implementing safer injection and waste disposal practices.

CONCLUSIONS: Disposal of injection waste poses challenges to staff at all levels of the health system in developing countries. Solutions are often developed in response to urgent needs, such as in the case of immunization campaigns. However, a more methodical approach to planning injection waste disposal services may have longer-lasting positive outcomes.

PARTNERS: USAID, WHO, World Bank, UNICEF, PATH/CVP, country-level HIV and immunization program staff

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F6
Managing Injection Waste: Experience from the Field

Infection Control in Health Facilities: Findings from Uganda

GREGORY PAPPAS

LEARNING OBJECTIVES: Participants will be able to describe key findings from the Uganda National Facility survey related to injection waste disposal and infection prevention and implications of the findings for improvements in injection waste disposal and infection prevention practices.

BACKGROUND: A nationally representative survey of government and NGO health facilities was conducted in Uganda in June 2002 to examine logistic system performance and HIV/AIDS services. The overall objective of the survey was to collect current information on: 1) logistics system performance and stock status of key health commodities, prior to the introduction of the new 'pull' request and distribution system for the health commodities; 2) the availability of HIV/AIDS prevention, care and support services, including other sexually transmitted infections, tuberculosis and other opportunistic infections, prior to the expansion of these services throughout the country; and 3) the training of staff who manage and/or provide these services. Sharps management and infection prevention practices were explicitly included in the survey in order to collect data on the health system and health worker performance in these important areas. The results of this survey were intended to provide information to health planners and organizations that work in these areas to promote improvements in system performance and the quality of services. The data will also be used as a baseline against which to measure the changes in logistics system performance and in HIV/AIDS support services.

METHODOLOGY AND RESULTS: Two hundred thirty-eight health facilities at all levels of the health system (including 12 district warehouses) were randomly selected and surveyed using a standardized instrument. Key results relate to sharps management and infection control practices, including use of sharps containers, disposable syringes, soap for hand washing, water for hand washing, soaking devices in disinfectants and the functioning of sterilization equipment. The commodities and equipment observed in facilities were evaluated in reference to universal precautions and levels of infection control to prevent the transmission of HIV.

CONCLUSIONS: Injection waste disposal practices in Uganda were found to be poor in all regards. Lack of availability of commodities required for safe and effective injection waste disposal posed a particular obstacle on health personnel to apply basic infection control procedures. These findings will assist health policy-makers and donors to focus attention on increasing availability of essential health commodities to ensure safe and effective disposal of injection waste.

PARTNERS: The Deliver Project, Aim Project, Macro International, Inc., CDC, USAID, health facility staff at the country level

ADDITIONAL AUTHORS: Erika Ronnow, Dana Aronovich, Allison Cochran, Paula Nersesian, Steve Wilbur, Nancy Fronzak

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F6
Managing Injection Waste: Experience from the Field

Safe Needle Removal to Manage Infectious Sharps

JANET VAIL

LEARNING OBJECTIVES: By the end of the session, participants will be able to recognize that needle removal is a safe and viable approach to needle and syringe disposal.

BACKGROUND: Procurement of autodisable (AD) injection devices is being mandated for immunization programs as a tool against re-use of unsterile syringes and needles. Ironically, the increased use of AD syringes will result in an increase of contaminated needles and syringes that require disposal. Current methods of used syringe and needle management in developing countries include collection of waste in sharps disposal boxes. However, disposal boxes are often unavailable (compromised by the large number of syringes used in the health center for curative purposes and not supplied with sharps boxes), unused or not disposed of properly. In outreach settings, the boxes lack sufficient portability. Needle destroyers are used to burn the needle tip. Its drawbacks include high price, maintenance requirements, inconsistent or incomplete destruction of needles, and electrical power requirements. Our objective is to advance acceptance and availability of simple, inexpensive and safe needle removers. The needle is removed from the syringe immediately after the injection, whereupon two forms of waste are created: defanged syringes and contained needles. Syringes without needles can be disposed of by incineration or microwaving, rotoclaving, hydroclaving and chemical disinfection at a disposal site. Authorized syringe recycling as plastic scrap is also an option. The small remainder of the waste volume is the contained needles, which can be disposed of in a protected sharps pit (as designed by Médecins Sans Frontières). The volume of the sharps waste is reduced by 99 percent compared to when the needles are attached to the syringes. Needle removers have been evaluated in Senegal and India, and device designs modified to incorporate user feedback. Devices appropriate for developing country use are expected to be available in 2003.

CONCLUSIONS: Needle removal is one component of a more comprehensive infectious sharps waste management system that must include a final step for disposal of removed needles and defanged needles.

PARTNERS: USAID, WHO, immunization program staff at the country level

ADDITIONAL AUTHORS: Glenn Austin, Michael Free, Claudia Harner, John Lloyd, Nancy Muller, Carib Nelson, Joanie Robertson, Bill Van Lew

ABSTRACTS

G1
Improving Maternal and Child Health in Urban Slums and Squatter Settlements

Challenges of Urban Programming for Child Health

SIDDHARTH AGARWAL

LEARNING OBJECTIVES: Participants will be able to discuss data collection and pro-poor programming approaches for meeting the challenges of improving child health in urban slums. Case studies will highlight recent experiences in India and Bangladesh.

BACKGROUND: The quest for better livelihood opportunities has led to large-scale migration and the mushrooming of slums in Indian cities. In the last decade, as India grew at an annual average of 2 percent, urban India grew at 3 percent, mega cities at 4 percent and slum populations by 5 percent. Recent studies show that the health of the urban poor is as bad or worse than that of rural counterparts. As a result, thousands of unnecessary maternal, child and adult deaths, and millions of days of disability occur each year. The health status of the urban poor vis-à-vis the rich underlines the need to target resources and efforts where they are most required. This is all the more crucial in urban programming because average statistics reflect a skewed image of the health of the urban poor, and poor urban dwellers often reside in unrecognized pockets and are missed by development programs or surveys. The USAID/Environmental Health Project/India Urban Health Program targets urban slum child health in coordination with many stakeholders: public sector services of health, water and sanitation; NGOs and community-based organizations — the organized face of the community; private providers; and charitable hospitals. The paper focuses on partnership models for furthering key child health priorities in the slums of Indore, and the consultative learning process that helped outline these directions. It also outlines lessons learned that provide rich insight into a host of programmatic issues that are better addressed through this learning approach.

CONCLUSIONS: Regular consultations between program team and stakeholders led to a plan responsive to the urban challenge. Participatory vulnerability mapping helps communities identify degrees of health vulnerability among different slums and leads to improved resource targeting. Using urban poor-specific data or qualitative information helps assess the real plight of the underserved urban slum dweller. A facilitated process leading to emerging partnerships and coalitions is an effective approach to programming.

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G1
Improving Maternal and Child Health in Urban Slums and Squatter Settlements

Data on the Health of Urban Poor Children

FRED ARNOLD

LEARNING OBJECTIVES: Participants will be able to discuss data collection for meeting the challenges of improving child health in urban slums.

BACKGROUND: Policies and programs aimed at improving health among the urban poor require a solid base of reliable, up-to-date data on both poverty and health status of the population. Some of the most important cross-national data on child health in urban areas has been collected as part of the demographic and health surveys (DHS) program in over 150 surveys in 70 developing countries. This paper highlights important issues in collecting data on the health of urban poor children, using examples from recent DHS surveys. Several issues must be considered when planning and implementing surveys that will be accepted by policy-makers and program planners. The first set of issues involves the definition of the urban poor. Many small-scale surveys have been conducted among urban slum populations. Although that is an appropriate focus for guiding child health programs based in urban slums, the DHS surveys show that much of the urban poor population does not live in slum areas, and many residents in slum areas are not in the poorest segments of society. A related set of issues has to do with the measurement of poverty. Reliable measures of income and consumption have proven to be extraordinarily difficult to collect. DHS has taken a different approach by basing the measurement of wealth on household assets. Recent research has demonstrated that wealth indices created from DHS data are strongly related to health inequities in children. Another critical issue is the representativeness of samples of urban poor children. Finally, it is important to consider sampling errors and confidence intervals of health and poverty indicators, especially when attempting to measure changes over time.

CONCLUSIONS: Collection of data on the health of urban poor children requires a clear definition of the population under study, scientifically sound methods of measuring poverty, a recognition of the importance of obtaining representative samples of the target population, and careful attention to sampling errors.

G1
Improving Maternal and Child Health in Urban Slums and Squatter Settlements

Making It Work: Epidemiological Profile and Critical Interventions for Dhaka Poor

W. ABDULLAH BROOKS

LEARNING OBJECTIVES: Participants will be able to discuss epidemiological data collection and pro-poor programming approaches for improving child health in urban slums. Case studies will highlight recent experiences in Bangladesh.

BACKGROUND: Infectious diseases account for over half of all deaths in developing countries. Much is attributable to the unplanned transition of people from rural to overcrowded urban areas. We recorded a population increase from 70,000 to 140,000 in a 4-sq km (1.5-sq mile) area between 1998 and 2000 in a Dhaka urban slum, while health, water and sanitation services remained inadequate. The objective was to identify the major health problems of the urban poor and determine which interventions, using sustainable technologies, have the greatest impact on disease reduction, and to provide evidence-based recommendations for urban-specific disease control.

METHODOLOGY AND RESULTS: An operational infrastructure was created in an urban slum with: 1) demographic surveillance; 2) active disease surveillance; 3) clinical service provision; 4) intervention-specific training; and 5) monitoring and evaluation for all surveillance, intervention and training activities. Surveillance has targeted pneumonia, diarrhea and dysentery, typhoid fever, dengue and other febrile illnesses, patterns of health-seeking behavior and vaccine coverage rates. Tuberculosis studies are beginning. Primary prevention interventions are underway, including vaccine trials. The predominant disease pattern is acute infection, including respiratory infection (pneumonia), diarrhea and dysentery, typhoid fever, dengue fever and dengue hemorrhagic fever, and possibly tuberculosis. Children less than 5 years comprise 80 percent of pneumonia (less than 2 years incidence=1.8 episodes/child/year), 72.6 percent of diarrhea, 68.6 percent of shigella dysentery, and 51 percent of all typhoid fever (less than 5 years incidence=18.0/1000). Results of dengue are pending, but the overall incidence is nearly 2/1000/year and is increasing. Overall immunization rates are low, suggesting poor health-care access.

CONCLUSIONS: The epidemiological profile of the Dhaka urban poor is one of acute infectious disease, possibly linked to overcrowding, inadequate sanitation and health-seeking behavior. Infection rates are highest among young children. These data suggest that disease prevention, particularly pneumonia and typhoid, among young children may have the greatest impact on disease reduction.

PARTNERS: USAID, Swiss Development Corporation, Johns Hopkins University, International Vaccine Institute, National Institutes of Health, Centers for Disease Control and Prevention, the University of Tokyo

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G2
Best Practices for Reduction of Maternal Mortality: Experiences from Egypt

Reducing Maternal Mortality and Morbidity in Egyptian Obstetric Departments Through Quality Assurance

WAFAIE EL-SAKKARY

LEARNING OBJECTIVES: By the end of the presentation, participants will be able to explain the Healthy Mother/Healthy Child quality assurance system in obstetric departments in district hospitals in Upper Egypt, and to identify the key elements of the quality assurance system that contribute to improvement in the quality of maternal services.

BACKGROUND: Quality assurance activities within the obstetric departments in district hospitals in Upper Egypt have a prime importance for provision of quality care in order to reduce maternal mortality. These activities are divided into two major areas. The first area is the recognition that leaders have a profound influence on the philosophy of quality management. Quality assurance training was conducted to produce leaders at all levels who understand the transformation required and to help deliver it. The second area is to create an ongoing monitoring system that embraces the concept of continuous quality improvement. The different aspects of obstetric care that have the greatest impact on maternal mortality are the focus of continuous monitoring, evaluation and improvement activities. For this reason, a mixture of structure, process and outcome indicators have been developed and used in self-assessments. The indicators translate well-communicated explicit standards and protocols that reflect important aspects of care. Regular review and production of quality assurance reports is the basis of identifying problems, and developing and implementing action plans for improvement. In addition to this, such reports measure department and practitioner performance patterns and trends over time in compliance with standards.

CONCLUSIONS: The ability to deliver safe, effective and high-quality care within obstetric departments requires the commitment of health leaders equipped with quality management skills. Explicit and transparent standards are essential for achieving the quality care provision. Important aspects of care should be regularly monitored and continuously improved. Involvement of all the staff members is also required for ownership and success.

PARTNERS: USAID, Ministry of Health and Population, Egypt

ABSTRACTS

G2
Best Practices for Reduction of Maternal Mortality: Experiences from Egypt

The National Maternal Mortality Study: Egypt, 2000

ESMAT MANSOUR

LEARNING OBJECTIVES: Participants attending this session will be able to assess the remarkable decline in the maternal mortality ratio (MMR) in Egypt, and to identify the causes/interventions leading to the dramatic decline.

BACKGROUND: Maternal death is a tragedy affecting an estimated 600,000 women worldwide every year. In Egypt alone, approximately 600 women die annually from maternal causes. Information on maternal mortality is essential for strengthening preventive programs and assessing their impact.

METHODOLOGY AND RESULTS: This study was conducted to estimate maternal mortality, identify its medical causes and determine avoidable factors contributing to maternal death. A representative sample of 8,497 female deaths aged 15–49 years was collected from all 27 governorates. Six hundred thirty-nine pregnancy-related deaths were identified through the use of screening questionnaires, and 585 maternal deaths were confirmed after home interviews. Providers aware of deaths were confidentially interviewed by governorate committees, which ascribed causes of death and avoidable factors. The maternal mortality ratio was 84/100,000 live births in 2000. Most deaths occurred during delivery or 24 hours after (49 percent), or during the six weeks postpartum (27 percent). Half of the time, the fetus/infant also died. The majority (93 percent) of women who died had sought medical help. Direct causes contributed to 77 percent of deaths. Hemorrhage was the leading direct cause (38 percent), followed by hypertensive diseases of pregnancy (22 percent). Cardiac disease was the leading indirect cause of death (13 percent). Substandard care by health providers was the leading avoidable factor, contributing to 54 percent of maternal deaths. Delay in recognizing danger signs and in care-seeking was the most frequent patient/family factor (30 percent). Shortage of blood was the most frequent health-facility factor (16 percent).

CONCLUSIONS: Maternal mortality in Egypt was reduced to 84/100,000 in 2000 from 174/100,000 in 1992-1993 (or 57 percent since 1992). Further reductions will depend on continuing to strengthen health systems and improve the knowledge and capacity of women to maintain their health. In the future, a national surveillance system will be more effective than large-scale studies for monitoring maternal deaths.

PARTNERS: Ministry of Health and Population, Egypt, USAID, John Snow, Inc.

ADDITIONAL AUTHORS: Oona Campbell, Reginald Gipson, Nahed Matta, Esmat Mansour, Adel Hakim Issa, Bothina El Deeb

G2
Best Practices for Reduction of Maternal Mortality: Experiences from Egypt

Best Practices for the Reduction of Maternal Mortality in Upper Egypt

NAHED MATTA

LEARNING OBJECTIVES: Participants attending this session will identify the key interventions and methods implemented for reducing maternal mortality in Upper Egypt, and lessons learned and programmatic issues related to the implementation of the interventions.

BACKGROUND: The goal of the USAID-funded Healthy Mother/Healthy Child Project is to reduce maternal, neonatal and child mortality in Egypt by improving the quality, effectiveness and use of reproductive and child health services in public and private health facilities and households. The Egyptian Ministry of Health and Population (MOHP) has implemented a variety of key interventions to assist in the reduction of mortality rates, with technical support provided by local and international partners. Project efforts, which began in 1995, were focused on five governorates in Upper Egypt where maternal and child health indicators were poorest. Achievements to date have been overwhelmingly positive. The results of the Egypt 2000 National Maternal Mortality Survey indicate that the maternal mortality ratio has been reduced by 52 percent over the last 10 years.

CONCLUSIONS: Many factors have contributed to the reduction of maternal mortality. Some key interventions and methods for reducing maternal mortality include the development and dissemination of obstetric and neonatal protocols, training of health providers using competency-based training (CBT) methodologies, the upgrading of delivery rooms and maternity wards, emphasizing infection control procedures, the development of quality assurance management and monitoring systems, the initiation of on-the-job clinical supervision, implementation of community-level activities and the use of IEC (information, education and communication) materials and mass media campaigns. Within each of these key interventions, specific lessons have been learned and the interventions modified accordingly. Continued improvements in infant, child and maternal health are expected. The Egyptian MOHP is committed to further reduce the national maternal mortality ratio by 42 percent by 2007. In order to assist in the achievement of this goal, project efforts will be expanded to cover a cumulative total of 75 districts in nine governorates.

PARTNERS: MOHP, Egypt, USAID, John Snow, Inc.

ADDITIONAL AUTHORS: Reginald Gipson, Esmat Mansour

ABSTRACTS

G3
Advancing Global Alliances for Health: Communication Tools and Strategies

Building Support: Communicating the Importance of Public Health

SANDRA JORDAN

LEARNING OBJECTIVES: Participants attending this session will be able to use communications to increase awareness of and support for development assistance for critical health needs.

BACKGROUND: Since the 1990s, the USAID Office of Population and Reproductive Health has been branded by a negative, we don't do abortions. One result has been a decline in public understanding of USAID's work, why it's important, and confusion over what constitutes family planning (FP) and reproductive health (RH) assistance. With increased politicization of FP/RH issues, proactive communications became an urgent priority. USAID therefore implemented a new communications strategy that concentrates on putting a face on global programs. Through soliciting human interest stories from the field, reaching out to non-health organizations to communicate with their grassroots, working closely with USAID missions to improve their communications efforts, and increasing and disseminating materials for public consumption, USAID has increased awareness and motivated additional support from various stakeholders. By proactively finding and disseminating our stories to the media, to donors, to legislators and to the general public, USAID is increasing commitment to global health, which can translate into more resources for activities.

CONCLUSIONS: Telling the story is fundamental to all development programs and organizations must commit to making communications an essential part of their operations. While recent world events have enhanced public understanding of the benefits of development assistance, this window of opportunity will not remain open for long. We must communicate the crucial role public health plays in development if we are to generate the public understanding and commitment to our work that can translate into budget and policy support. We especially must communicate the linkages between health care and its powerful role in sustainable development worldwide. The communications strategy undertaken by USAID can be replicated by any organization working in public health. Results from USAID's communication initiative identified core constituencies and developing messages and materials specifically for these audiences; created appropriate materials and vehicles to communicate clearly and concisely with key constituencies; increased understanding of organizational goals and activities; enhanced support for international health assistance; and developed communications tools that have proven effective in a host country environment as well as in the United States.

PARTNERS: USAID, Department of Health, South Africa, John Snow, Inc.

G3
Advancing Global Alliances for Health: Communication Tools and Strategies

Using Communications to Support Technical Activities in Uganda

PENELOPE A. RISEBOROUGH

LEARNING OBJECTIVES: Participants attending this session will understand the role that communications can play in supporting and expanding the impact of technical activities while also promoting the impact and successes to donors and other external audiences.

BACKGROUND: Field projects are typically funded to do targeted technical work around specific areas of importance. However, it is becoming increasingly important for even the most technical projects to find ways to talk about their work to general audiences, including funders, the United States Congress and individual donors. In Uganda, the USAID-funded AIDS/HIV integrated model (AIM) district program recently developed a communications strategy with two overarching goals: to support its technical work and to communicate successes to donors and partners in accessible ways. Recognizing that good communications helps achieve a multiplier effect, the strategy uses communications to lay the groundwork for AIM's technical activities as well as to document successes and reach key target audiences via various modes of communication. The process used to develop the AIM program communications strategy will be presented, and some of the communications areas that are supporting a technical initiative, the nationwide launch of a new HIV/AIDS VCT training manual, will be highlighted.

CONCLUSIONS: Effective communications should be used as a vehicle to support technical program development and activities in-country and, once completed, highlight results and accomplishments in ways that appeal to donor and public audiences. It is incumbent upon technical staff to recognize the importance of easily accessible documentation of technical achievements and to contribute to communications efforts that benefit the project goals and appeal to donors.

PARTNERS: AIM Program, USAID, CDC, Ministry of Health, Uganda, World Education, Inc.

ADDITIONAL AUTHORS: Caroline Odongo Turyatemba, Maurice Adams

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G3
Advancing Global Alliances for Health: Communication Tools and Strategies

Communicating Health Impact: Lessons from South Africa

CARMEN URDANETA

LEARNING OBJECTIVES: Using the experience of an international health project in South Africa, participants will learn how to use simple communications tools to improve documentation of program impact and lessons through stories.

BACKGROUND: Throughout its first five years of operation, the South African Equity Project realized many program achievements, but continually struggled to effectively document and communicate results to broader audiences. In 2001, Equity implemented a new communications strategy, which includes stories told from the personal perspective of clients, providers and partners, to explain the project's vision, challenges, lessons, successes and impact on the health of underserved communities throughout South Africa. By using simple tools, investing additional resources, and routinely incorporating communications into program activities, Equity has been better able to document the impact of its technical assistance and that of project partners and counterparts to great success. Not only have Equity stories drawn the attention of a wider audience, but the project has been able to link the additional attention into ongoing support for primary health care interventions.

CONCLUSIONS: It is increasingly critical for organizations striving to achieve social missions around the world to effectively communicate project impact and lessons to broader audiences. New demands by donors for social returns on investment require organizations to more effectively document their successes. At the same time, sharing lessons learned across countries improves the ability of organizations and programs to achieve results and improve primary health care in challenging settings. The lessons learned from the Equity Project experience can be applied to other international NGOs with field projects and offices. Further, by transferring basic skills in documentation, field partners are better able to continue to strive for health improvements after technical assistance has ceased. Results from South Africa include: 1) increased awareness of project activities to various audiences; 2) enhanced support for health interventions in a challenging and resource-constrained environment; 3) field-tested simple communications tools to help local nurses and technical staff inform project successes; 4) enhanced the capacity of local organizations to communicate their missions and achievements and strive for additional resources; and 5) enhance the legacy of extensive technical work and improvements in primary health care after project funding ceases.

PARTNERS: Department of Health, South Africa, USAID

ADDITIONAL AUTHORS: Gretchen Hurley, Tracy Leach

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G4
Enabling Environments: Foundations to Mobilize Against HIV/STIs

A New Sense of Place: Community Mapping in the Dominican Republic's Bateyes

ALFREDO FORT

LEARNING OBJECTIVES: By the end of the presentation, participants will be able to describe the components of a community-mapping exercise, and the intended and unintended roles the maps are playing in a particular reproductive health intervention.

BACKGROUND: The PRIME II Project is working to improve the reproductive and maternal/child health and health-seeking behavior of residents of the Dominican Republic's batey communities. The bateyes are populated predominantly by Dominicans of Haitian descent, many of whom came to the country to work in the sugarcane fields and later lost their livelihood when the industry was privatized. Health promoters living in the bateyes are trained by PRIME to provide family planning and preventive reproductive health services, including counseling, outreach education, referrals, community-based provision of family planning methods and sexually transmitted infections/HIV prevention. Extensive baseline data collection activities included a community-mapping and survey exercise that has also been used to designate which households are served by each promoter. The promoters and other residents of the bateyes became active in the mapping process, and the maps soon assumed broad significance in unforeseen ways. In communities that had never been charted on paper, the maps provided a new-found sense of place and pride, and reinforced the notion of the bateyes as permanent rather than temporary settlements. Mayors and community officials requested copies, and provincial agencies involved in delivering a variety of services have expressed interest in using the maps to make infrastructural improvements.

CONCLUSIONS: The enthusiasm generated by the maps bodes well for the implementation of PRIME's intervention, the success of which depends on community participation and support. If the maps indeed help to propel additional development projects to improve the physical environment and infrastructure of the bateyes, then they will have also succeeded as a mini-intervention of their own: a fortuitous synergy of improved reproductive health care and community identity and empowerment.

PARTNER: Dominican Institute for Community Action

ADDITIONAL AUTHOR: Mark B. Padilla

G4
Enabling Environments: Foundations to Mobilize Against HIV/STIs

Improving the Social Environment with Participatory Learning and Action as an Intervention for an Adolescent Reproductive Health Project in China

QIAN GENG

LEARNING OBJECTIVES: Participants will be able to describe how participatory learning and action (PLA) can be used in adolescent reproductive health (RH) programs, not only to learn about young people's needs, the service environment and adults attitudes toward youth sexuality but also how PLA can be used as a learning process for the project staff and other adult stakeholders to listen to youth, be better able to work with youth, and change attitudes regarding youth and their RH needs.

BACKGROUND: The China Youth RH Project began in 2000 to address the RH needs of up to 80 million youth in 14 project sites. The China Family Planning Association (CFPA) and Program for Appropriate Technology in Health (PATH) collaborated to meet the following objectives: increase adolescents' self-esteem, awareness of positive gender and human rights values, and safer sexual practices; increase adolescents' access to and use of quality RH services; create a supportive environment for programming at the national, community, and school levels; and improve the national-level response to adolescent RH issues by building the capacity of CFPA to advocate for, plan, implement and evaluate innovative interventions for adolescents. An extensive intervention involving PLA was undertaken at the beginning of the project to assess youth reproductive health needs with the voices of youth and context of the communities being taken into consideration. Fifty-two local family planning association members from the project sites were trained in PLA techniques. At first, they were hesitant about using these types of participatory techniques, as they believed that they already knew what young people needed. However, the project staff agreed to take their new skills back to their sites and to practice the techniques by conducting PLA activities, such as focus group discussions, mapping exercises, and ranking exercises, in their communities. The participatory nature of the activity not only ensured that youth and other community members' voices were heard and used in project design, but also began a shift among CFPA staff from didactic toward participatory methods for research and training.

CONCLUSIONS: The most remarkable and wide-reaching outcome of the PLA activities was the change in attitude among project staff and other adult stakeholders toward youth, especially marginalized youth. The adults gained the skills to be able to listen to youth, their concerns and needs, and have gained appreciation of their views. This change in attitude has carried across all other project components: from adding to their skills to conduct life-planning skills training with youth to enabling them to be more thoughtful and effective advocates for the youth in communities and even at the national level. The project owes its success, in many ways, to this intensive PLA intervention at the beginning of the project, which informed the project design and shifted the attitudes of many people involved in the project.

PARTNERS: CFPA, PATH

ADDITIONAL AUTHORS: Waranuch Chinvarasopak, Yongfeng Liu, Lisa Mueller

G4
Enabling Environments: Foundations to Mobilize Against HIV/STIs

Role of Government, Communities and Political Change in Promoting an Enabling Environment for Effective HIV/AIDS Prevention

NAKKU ROSETTE

LEARNING OBJECTIVES: Participants attending this session will be able to understand the role played by government, community and political change in promoting effective HIV/AIDS programs.

BACKGROUND: The Paris Declaration on HIV Prevention and the Jarkata Declaration on Health Promotion state the importance of an enabling environment to support effective health promotion. HIV health promotion sits inside political, economic and social structures that often stigmatize and marginalize communities vulnerable to HIV and people living with HIV/AIDS (PLWHA). These structures and contexts can seriously undermine the effectiveness of HIV prevention strategies. Equally, the meaningful contribution and involvement of communities at risk of HIV and PLWHA in policy development bring much expertise to HIV prevention programs. Since 1990, the National AIDS Control Programme has been involved in policy development processes that demonstrate political approaches to HIV prevention and program planning, the development of a national HIV/AIDS framework, school sex/health education strategy and community approaches to HIV prevention. Action taken around these formal public health policy development processes will be used to exemplify challenges in increasing fundamental environmental factors that act as constraints to health promotion. These challenges include the impact of legislation (e.g., anti-PLWHA discrimination laws, mandatory HIV testing, condom access restrictions) promoting the role of PLWHA and affected communities as integral partners in planning.

CONCLUSIONS: The role of changing environments in which HIV/AIDS prevention takes place requires us to look beyond behavior change models to models of political action to address law reform and institutional discrimination. There is a need to recognize the task of addressing environmental and structural barriers to HIV prevention and develop political strategies alongside health promotion strategies.

PARTNERS: Nkumba AIDS Community Initiative, National AIDS Control Programme and Uganda AIDS Coalition

ADDITIONAL AUTHORS: Tamale Moses, Navuga Robinah, Nalubowa Angela

ABSTRACTS

G5
Environmental Impact and Challenges among Displaced Populations

Linking Environmental Concerns and Health in Complex Humanitarian Emergencies

RHODA MARGESSON

LEARNING OBJECTIVES: Participants attending this session will be able to better understand the impact of complex humanitarian emergencies on the environment and the links to health, the relationship between refugees and the environment, the broader relevance to politics, refugee security, food security, health and environmental protection.

BACKGROUND: The link between natural resources and conflict is not new and yet, in war, destruction to the environment has largely been viewed as a separate, less urgent concern. The impact of complex humanitarian emergencies (CHEs) on the environment is still considered a peripheral issue. Using Afghanistan as a case example, this paper will explore the environmental effects of conflict during humanitarian crises and the ways in which these problems are (or should be) addressed and incorporated into an intervention strategy at each stage in the conflict cycle. The paper will examine the environment-health link in both refugee relief operations and the post-emergency transition in Afghanistan. More broadly, it will consider the factors that affect the intensity and scope of attention given to the environment in strategies for prevention, mitigation and reconstruction management before, during and following a humanitarian crisis. If time and space allows, it will draw comparisons to the 1999 Kosovo conflict (Albania and Macedonia during the refugee relief operations and Kosovo during the post-emergency transition.)

CONCLUSIONS: The links between the environment and CHEs may reveal policy prescriptions for better managing critical health issues in conflict settings. The Afghanistan case may demonstrate ways that environmental effects can be treated in an integrated manner from the start of the emergency through reconstruction. In light of the growing number of CHEs, this may be a way to further humanitarian effectiveness of intervention and make a more successful transition to reconstruction management, while preserving the quality of the natural environment.

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G5
Environmental Impact and Challenges among Displaced Populations

The Effects of War on Fertility: The Case of Rwanda

THERESE MCGINN

LEARNING OBJECTIVES: Participants will gain an appreciation of the factors, including the refugee experience and post-war repatriation, rehabilitation and development, that influence fertility in post-war Rwanda.

BACKGROUND: Data on the effects of war on fertility have been limited and somewhat contradictory. Understanding is limited by overall lack of data as well as the difficulty of isolating the effects of war on health service delivery, its effects on individuals' fertility-related attitudes and behaviors, themselves influenced by war, and the more familiar sociodemographic variations normally found among and between population groups. Rwanda's pre-war national family planning program began in the early to mid-1980s and was relatively strong. The contraceptive prevalence rate was lower in the post-war (2000) than in the pre-war period (1992) as measured by demographic and health surveys (DHS). The current study was an attempt to understand the factors influencing the change in prevalence.

METHODOLOGY AND RESULTS: Secondary analysis of 1992 and 2000 cross-sectional health and demographic surveys and a 2001 service availability survey in Rwanda was the principal method used. Additional data on the degree to which specific prefectures and communes were affected were culled from refugee movement and repatriation data and included in the analysis.

CONCLUSIONS: The analysis suggested that several factors have influenced post-war reproductive behavior in Rwanda. These include the degree to which individuals' area of current residence (in 2000) was affected by the war (as measured by the level of population movement); health service availability and quality; and the familiar sociodemographic characteristics, such as age, parity, education and prior contraceptive use. The relative contributions of these factors to the prevalence decline are discussed. The analysis also suggested that despite the national and individual trauma suffered in the war and in the post-war period, there is a demand for family planning services in Rwanda that is not fully met by existing services.

ABSTRACTS

G5
Environmental Impact and Challenges among Displaced Populations

The Integration of Refugee and Local Health Systems

ELIZABETH ROWLEY

LEARNING OBJECTIVES: Participants attending this session will be able to identify the 10 steps of quality design relevant to the integration of district and refugee health services.

BACKGROUND: The West Nile districts of northern Uganda are host to approximately 120,000 refugees driven from civil war in southern Sudan. While the refugees have been generously hosted by Uganda with land and asylum, UNHCR has provided them with a service structure, including health services. In 1999, UNHCR and the Government of Uganda jointly decided that the local governments of Arua, Moyo and Adjumani Districts would take over refugee services. With technical support from the West Nile Quality Design Project, health managers in the Adjumani District worked together to plan the integration of district and refugee health activities using a modified version of the 10 steps of quality design. Quality design is the systematic creation of new services or processes or the redesign of existing services. It incorporates features that meet stakeholder needs while taking into account the resources available. Quality design is normally applied within a single health system. The situation in Adjumani required an innovative response, as the challenge was to combine the activities of two different systems. A quality design team, composed of key stakeholders from both systems, undertook activities to create a functional plan for the integration of district and refugee immunization systems in particular. Key accomplishments include consensus-building and team formation, research on manager, provider and user perspectives, and the adaptation of quality design steps in order to formulate a solid action plan for service integration that explicitly incorporates user needs.

CONCLUSIONS: The experience presented demonstrates that health managers can use quality design to create practical plans for implementing change, as evidenced by a successful adaptation of quality design and the resulting plans for an integrated immunization system. Whereas quality design had previously been used primarily in single-system hospital-based settings, this case study further illustrates how quality design can be used to bring together two distinct service delivery systems at the peripheral levels. The hallmarks of quality design highlighted in this experience are: establishment of leadership in the change process; creation of a common vision (consensus) among all stakeholders involved on who is implementing change and in what areas; use of a systems approach, viewing health service delivery in terms of inputs, processes and outputs; and collection and application of health-care manager, provider and user feedback on services in place.

PARTNERS: The Johns Hopkins University Bloomberg School of Public Health, USAID, University Research Co. and the Mellon Foundation, Save the Children (UK) Uganda Programme, Adjumani District Health Services (Uganda), Africa Humanitarian Action – Uganda, UNHCR Uganda

ADDITIONAL AUTHORS: Gilbert Burnham, Diana Silimperi, Ya-Shin Lin

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PHYSICAL ENVIRONMENT AND HEALTH: INDUSTRIALIZATION AND DEVELOPMENT

Comparative Environmental Health Risk Assessment in Chennai, India

Kalpana Balakrishnan

LEARNING OBJECTIVES: Participants will be able to gain insights into health and economic risks for key environmental pollutants in Chennai, India, and understand particular challenges in the design of environmental management plans that address such risks in developing country settings.

BACKGROUND: Roughly 25-33 percent of the global burden of disease may be attributable to environmental factors, with developing countries bearing the largest share of this burden. Integration of health risks into the environmental management process is therefore crucial for sustainable development initiatives in developing countries. A comparative health risk assessment study was executed in an industrial zone of Chennai, India, aimed at quantifying health risks attributable to air pollutants and comparatively ranking them against other local environmental concerns.

METHODOLOGY AND RESULTS: Environmental information was gathered from the available air and water quality monitoring databases. In addition, primary data were collected in each of the 48 wards of the municipal zone to refine available environmental information. Wherever available, dose-response information obtained specifically from developing countries was applied to calculate health risks. Cross-sectional epidemiological information was also gathered by the administration of an environmental health assessment questionnaire in a stratified random sample of about 900 households within the zone. The health and economic risks from PM10, SO2, NOX, CO, lead and indoor air pollutants were compared to risks from microbial contamination of water (diarrheal diseases) and solid waste disposal (vector-borne diseases) to arrive at a common framework for ranking. Among air pollutants, risks from PM10 levels were the greatest, followed by lead and carbon monoxide. Risks from indoor air pollutants, largely due to use of biomass fuels, were very high in municipal wards that had a high concentration of homes using these fuels. Although risks from air pollutants are substantial, they are outweighed by risks from microbial contamination of water and solid waste disposal.

CONCLUSION: The study involved considerable stakeholder participation, including the state pollution control board and the city planners. The results of the study are expected to be used for the design of an environmental management plan for the city and aid environmental resource allocation.

PARTNERS: Madras School of Economics, Indira Gandhi Institute for Developmental Research

ADDITIONAL AUTHORS: Sankar Sambandam, Padmavathi Ramaswamy

PHYSICAL ENVIRONMENT AND HEALTH: INDUSTRIALIZATION AND DEVELOPMENT

POSTERS

Disaster Management for Gold Mining Accidents in Eastern Europe and Central Asia

Alexandru Ozunu

LEARNING OBJECTIVES: Participants will be able to describe the main aspects in disaster management of cyanide disasters with respect to a sustainable development.

BACKGROUND: Gold resources are a relevant economic potential of Romania and of other former communist states under a rapid development in joint venture mining companies, but the chemical extraction of gold with cyanide is a potential severe hazard for environment and health under the local conditions of unpreparedness to avoid and manage industrial incidents. Accidental cyanide spills may cause complex environmental disasters such as the spill near Baia Mare, Romania in January 2000. To investigate the risk of the cyanide leaching technology for health and environment exemplified by a detailed analysis of two accidental cyanide incidents, a transport accident of the KUMTOR mine near Barskaun (Kyrgyzstan) on May 20, 1998 and the large spill of tailings from the Aurul mine near Baia Mare in Romania on January 30/31, 2000, the European Commission (EC)-funded project IRCYL has been conducted as a research project.

CONCLUSION: The industrial development of the former communist states, especially in the chemical and mining sector based on existing natural resources, requires development of a major accident prevention policy. There will be a new duty imposed on operators of establishments that come within the scope of Seveso Directive on the control of major accident hazards involving dangerous substances. Associated with this, there will also be the requirements for the operator to have appropriate management systems for implementing the policy. Within the broad range of hazardous industrial activities, the industrial activities that come under the Seveso Directive criteria obviously get considerable attention because it represents an important step forward for a minimization of the risk of major industrial accidents. Specifically for the gold mining sector, a re-classification of the cyanide-based gold leaching technology as a chemical process should be debated. If the voluntary cyanide code is to be accepted, the following must be in place: the application of EC regulations for the transport of cyanide and the storage of tailings; and financial support by European banks, especially EBRD.

PARTNERS: Project staff, community project organizations

ADDITIONAL AUTHORS: Beate Pesch, Ulrich Ranft, E. Cordos, IRCYL Group

Job Exposure Profiles for Small-Scale Industries in Southern India

Sankar Sambandam

LEARNING OBJECTIVES: Participants will learn the scale of occupational exposures prevalent in small and medium tanning units of Tamil Nadu, India and gain insights into recent initiatives in these sectors to improve the status of occupational safety and health.

BACKGROUND: Nearly 50 percent of the tanneries nationwide are located in the state of Tamil Nadu. Although they account for a major share of export revenue for the country, many units in this sector operate out of premises lacking even the most basic facilities required for a safe work environment. Further, very few systematic studies have been undertaken to establish the status of occupational safety and health in these units. The present case study documents: 1) detailed hazard profiles for each process step; 2) exposure profiles for select hazards; 3) a health profile for the workers; 4) specific workplace improvements implemented in select tanneries; and 5) initiatives to build local capacities to sustain the sector-specific occupational safety and health maintenance efforts.

METHODOLOGY AND RESULTS: Industrial hygiene measurements were conducted for respirable dusts, toxic gases, including hydrogen sulfide, ammonia, formaldehyde and select other volatile organics according to protocols recommended by the NIOSH Manual of Analytical Methods in 20 work areas from eight different units selected randomly. Assessment of heat stress and noise exposures was also carried out. Health assessments were conducted on 256 workers from these units using a combination of direct physical examination, administration of an occupational symptoms questionnaire and pulmonary/audiometric tests. Levels of respirable dusts (5-25 mg/m3) and noise (95-110 dB) were the biggest concern in most work locations and improvements were made in many tanneries by implementing locally designed, low-cost engineering controls. Occupational health monitoring and surveillance programs were designed with active management participation. Hazard communication and emergency preparedness protocols, which were virtually nonexistent, were developed and training administered to sustain the same.

CONCLUSION: The present case study demonstrates what could be accomplished for a largely unorganized sector in modest settings through multiple stakeholder involvement. The study serves as a model for implementing similar programs for improving the welfare of working communities in the developing world.

PARTNERS: Central Leather Research Institute, All India Skin and Hides Traders and Manufacturers Association

ADDITIONAL AUTHORS: Kalpana Balakrishnan, Joerg Arnold, Padmavathi Ramaswamy

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Mapping the Relationship Between Population and the Environment

Kirk Riutta

LEARNING OBJECTIVES: Participants will recognize how geographic information system (GIS) technology can aid planners and policy-makers in formulating holistic and integrated policies and programs that consider the environment.

BACKGROUND: The Philippines is one of the hottest of the world's biological hotspots containing more than 52,000 described species, over half of which are found nowhere else in the world. Efforts to conserve this environment are challenged by the fact that many of the most pristine and valuable areas are also the places where human population is increasing most rapidly. Consequently, the state of the environment is at a critical point: only 5 percent of the coral reefs remain in excellent condition, only 20 percent of the original mangrove forest remains and 5 percent of old growth forest remains intact. Any investment of human and financial resources in these ecosystems requires an understanding of population and environment dynamics. As a result of this realization, Conservation International Philippines (CIP) has initiated an exciting USAID-funded project that will use GIS technology to map out population and environment variables for the entire country. Recently, CIP and partners completed the Philippine Biodiversity Priority-Setting Project (PBCPP) that identified 206 Philippine conservation priority areas. Gathering more than 300 local and international scientists and more than 100 broad-ranging institutions, the project created a set of national maps and an interactive CD-ROM to display and describe these critical habitats and their associated biodiversity. Habitat destruction in the Philippines is caused by a variety of forces, including unsustainable resource extraction, land conversion, poverty and population growth. The Philippine population is growing by 2.36 percent per year and will double in 29 years. Such growth puts immense pressure on the country's natural resources and is one of the root causes of biodiversity loss. As a follow-up to the PBCPP, CIP and partners will examine the role man plays in the condition of these fragile ecosystems. The GIS Demographic Project will create a digitized map using GIS technology to point out key population and environment data. The data gathered and overlaid in a national map will be analyzed and used as a tool to aid government and development agencies in planning holistic policies and activities that consider the relationship between population dynamics and the environment.

CONCLUSION: Specifically, the GIS Demographic Project demonstrates the ability of GIS technology to aid policy-makers and planners to develop holistic and integrated policies and programs that consider man's impact on the environment. Ultimately, replication of similar efforts is possible worldwide and could have long-term implications for the development of a wide range of population and/or environment policies and programs.

PARTNERS: Philippine National Economic Development Assistance, Philippine Parks and Wildlife Bureau

ADDITIONAL AUTHORS: Dario Pagcaliwagan, Perry Ong, Connie Morales, Mely Silverio, Oliver Coroza, Sheila Rodriguez

PHYSICAL ENVIRONMENT AND HEALTH: UNDERDEVELOPMENT

Acute Effects of Biofuel Cookstove Exposures among Guatemalan Women

Lisa Thompson

LEARNING OBJECTIVES: Participants attending this session will be able to describe five methods of exposure assessment used to characterize carbon monoxide (CO) levels and respiratory status among Guatemalan women who use improved stoves (planchas) and open fires.

BACKGROUND: Biofuel combustion is a major cause of indoor air pollution in developing countries, and has been linked to an increased incidence of respiratory diseases. The purpose of this exposure-control study was to compare the acute effects of woodsmoke exposure among rural Guatemalan women who cook over an open fire versus those who use an improved stove, a plancha. The researchers' hypothesis was that women who use planchas would have better pulmonary function and lower CO exposures than the open fire group.

METHODOLOGY AND RESULTS: In July 2002, 88 women, representing 45 planchas and 43 open fires, were recruited. Spirometry, exhaled CO and CO passive diffusion tubes were measured on all women before the morning fire was lit and after the mid-day meal. Forty-seven women wore personal CO data loggers. Twenty-two households were monitored with stationary particulate monitors. All women completed a questionnaire administered by trained fieldworkers. The CO passive diffusion tubes showed a mean concentration of 5.74 ppm (standard deviation (SD) 8.85) for the planchas and mean of 9.02 (SD 6.90) for open fires. Mean exhaled CO was higher among the open fire group both pre- and post-fire (open fire: pre-fire 5.29 ppm (SD 4.55), post-fire 6.52 ppm (SD 2.39); plancha: pre-fire 4.53 ppm (SD 1.45); post-fire 4.50 ppm (SD 1.97). For the plancha group, baseline lung function was better, and there was a smaller pre-post exposure decrease in FEV1 and FEV1/FVC ratio than the open fire group, although this difference was not statistically significant using a 2-sample t-test.

CONCLUSION: Open fires increased the risk of carbon monoxide exposure and decreased pulmonary function among this group of Guatemalan women. This study demonstrated the benefit of improved stoves among households that depend on biofuel combustion.

PARTNERS: Kirk Smith, John Balmes

ADDITIONAL AUTHOR: Sara Ash, Victorina Lopez, Maria Elena Lopez, Sandra Sanchez, Juana Cabrera, Lucila Fuentes

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PHYSICAL ENVIRONMENT AND HEALTH: UNDERDEVELOPMENT

Drinking Water and Environmental Sanitation

Ramesh Bdr. Koirala

LEARNING OBJECTIVES: Participants will know the real condition of drinking water and environmental sanitation in rural areas of developing countries, especially in South Asia.

BACKGROUND: Sunsari lies in Nepal's eastern development region and is one of the country's 20 terai (plains) districts. It has 49 village development committees and three municipalities. Inaruwa is the district's climate headquarters. The hypothesis was that the condition of drinking water and environmental sanitation is poor in rural areas of the terai in Nepal because of poverty and lack of health consciousness. The baseline survey sample was designed to provide district-level estimates of important indicators relating to drinking water and sanitation, and health and education of children. Multiple cluster survey methodology was adapted to select the sample. A two-stage sampling technique was adopted in order to select the households from the survey district. Interviews were then conducted with the heads of households and mothers or caretakers of children.

METHODOLOGY AND RESULTS: The baseline survey sample was designed to provide district-level estimates of some important indicators relating to drinking water and sanitation, and health and education of children. Multiple cluster survey methodology, with some modifications, was adopted to select the sample. A two-stage sampling technique was adopted in order to select the households from the survey district. Following this methodology, interviews were conducted with the heads of households and mothers or caretakers of children. Findings relating to water include: tube-well is the main source of drinking water in the district (76 percent); 94 percent of households have access to water within 15 minutes; 62 percent of households cover their water vessels. Thirty-eight percent of households have a latrine facility; while most of the children and adults use water for washing hands before meals, children in 21 percent of households and adults in 33 percent of households use soil to wash hands after defecation. Seventy-seven percent of households dispose of household waste within 50 feet of the dwellings and tube-wells/boreholes.

CONCLUSION: The majority of the population in rural areas of Nepal is not able to access safe drinking water and good environmental sanitation due to lack of awareness and resources. People, in general, are in need of safe drinking water and awareness programs on sanitation. The general health of people can be improved by running different programs on safe drinking water, sanitation and public awareness.

PARTNERS: Education and health care community/Nepal, community care, local government

ADDITIONAL AUTHORS: Rajendra Chapagaee, Ram Krishna Bhandari, Anita Gurung, Hari Prasad Tiwari, Radesh Biswas

Improving Living Conditions in Informal or Slum Settlements

Duke P. Gumede

LEARNING OBJECTIVES: Participants will be able to recognize the significance of community-based interventions to improving health and environmental conditions in informal settlements.

BACKGROUND: The importance of partnerships cannot be over-emphasized in addressing issues in cities of developing countries today. South Africa is such a country, with Cape Town one of those cities. Much urban development and rural underdevelopment have given rise to urban sprawl, resulting in the establishment of much-neglected informal settlements around cities. Issues arising from these are land invasions, overcrowding, high unemployment, destruction of biodiversity, health hazards and pollution of urban catchments and ground water as well as air pollution. Some problems in Joe Slovo informal settlement (population 15,000+, size 27 ha, density 556/ha) located 10 km east of the Cape Town CBD include frequent fires, flooding, stagnant open streams, littering, inadequate access, inadequate water and sanitation, and respiratory and dysenteric diseases, including HIV/AIDS. The city's interventions include extensive community consultation, establishment of project teams, relocation of dwellings, creation of fire-breaks and access tracks, installation of stormwater channels and pipes, installation of fire hydrants and wash troughs, provision of container toilets, electrification of dwellings, establishment of a green belt and food gardens, and a residents' database.

CONCLUSION: This in essence is a pilot project where the city has adopted an integrated approach to improving living conditions in informal settlements, an intermediate solution to the slow delivery of state formal housing. It is intended that lessons learned here will be implemented in the other 90+ settlements in the greater Cape Town Metropolitan Area. The success of this project is mainly due to community participation. The community members have played an integral part, from planning through implementation. They have taken ownership with a sense of pride and dignity, ensuring a long lifespan of service. We hope this partnership will be a long-lasting success story on the road to sustainability.

PARTNERS: City of Cape Town departments, local government politicians, community leadership structures, Langa Development Forum, Tsoga Environmental Resource Centre, Santam Cape Argus Ukuvuka Operation Firestop Organisation, National Botanical Institute, ESKOM (electricity supply utility company)

Prevalence and Correlates of Anemia among School Children in South Pakistan

Gul Nowshad

LEARNING OBJECTIVES: Participants will be able to identify the prevalence and risk factors for anemia among school children.

BACKGROUND: Micronutrient undernutrition, in its different forms and degrees, is still one of the most widespread nutritional deficiency states of infants and young children in Pakistan. Iron deficiency anemia is a serious micronutrient deficiency status as it diminishes learning in children.

METHODOLOGY AND RESULTS: The prevalence of anemia among children in rural villages of south Pakistan was estimated. Trained physicians examined children for clinical signs of anemia. Children were also examined for weight and height, and other information was obtained through a questionnaire. Z-scores of less than -2 standard deviations were used to define wasting and stunting in relation to the median of National Center for Health Statistics and Center for Disease Control standards. A total of 432 children out of 2,538 children (17 percent) aged 5-12 years had anemia. Female children compared to males were more likely to be anemic (21 percent versus 12 percent; odds ration (OR) 2.2, 95% confidence interval (CI) 1.74-2.73). Anemic children were more likely to be stunted (OR 1.29, 95% CI 1.00-1.96). Fathers with no education were more likely (OR 1.37, 95% CI 1.08-1.75) to have children who were anemic. Children living in mud houses were more likely to be anemic (OR 1.41, 95% CI 1.10-1.81) compared to children who lived in concrete or semi-concrete houses.

CONCLUSION: Iron deficiency anemia is a substantial public health problem among school children. Female children compared to males were more likely to be anemic.

PARTNERS: Aga Khan Health Services, Department of Community Health Sciences, Aga Khan University and Health Service Organization module, SPH, UTH

ADDITIONAL AUTHOR: Syed M. Shah

PHYSICAL ENVIRONMENT AND HEALTH: UNDERDEVELOPMENT

Tuberculosis Mitigation in the Aral Sea Disaster Zone

Olga Kim

LEARNING OBJECTIVES: Participants will be able to identify three social, economic and environmental factors that are contributing factors in perpetuating the spread of tuberculosis (TB), and to identify strengths and limitations of at least three incentive mechanisms aimed to improve patient compliance rates with directly observed therapy, short course (DOTS) treatment.

BACKGROUND: Scientists consider the drying up of the Aral Sea, once the world's fourth largest lake, one of the greatest ecological disasters of all time. Following three decades of harmful farming and irrigation practices to grow cotton during the Soviet era, the lake that former fishing and agricultural communities depended on for survival lost two-thirds of its volume. The Aral Sea environmental disaster, along with the economic and health care collapse of the countries of the former Soviet Union, has resulted in increased respiratory illnesses, poor nutritional status and increased vulnerability to re-emerging diseases such as TB, which has reached epidemic proportions throughout the Aral Sea Zone. As DOTS is introduced in the Central Asia region, a growing public health concern is the large numbers of noncompliant patients participating in DOTS. Noncompliance with DOTS is a major cause of the spread of multidrug resistant forms of TB in the region. To address this public health crisis, the American Red Cross (ARC) and Kazakh Red Crescent Society are partnering with the Center for Disease Control and Prevention (CDC) and the United States Department of Agriculture (USDA) to implement an operational research study on the efficacy of multiple forms of low-cost, patient-oriented incentives for improving patient compliance rates with DOTS. This study in rural and urban areas of Kyzlorda Oblast, Kazakhstan will contribute to public health knowledge of effective strategies for ensuring that TB patients take their drugs regularly, on schedule and for the full duration of their treatment.

CONCLUSION: Through sharing lessons learned from its Tuberculosis Mitigation Project in the Aral Sea Zone, ARC/KRCS will promote the replication of proven low-cost, high-impact and holistic interventions designed to reduce the prevalence of re-emerging infectious diseases, such as TB.

PARTNERS: USDA, Red Crescent Society of Kazakhstan, Red Crescent Society of Uzbekistan, CDC

ADDITIONAL AUTHORS: Catherine Stanley, Rowan Wagner, Carol Puzone

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SOCIAL ENVIRONMENT AND HEALTH: CHILD AND ADOLESCENT HEALTH

POSTERS

Areca Nut Use among Rural Primary School Children in Pakistan

Rashida Bano Syed

LEARNING OBJECTIVES: Participants will be able to identify the burden and determinants of areca nut use among young children in a developing country.

BACKGROUND: Areca nut (betel nut) is chewed by itself, in various scented preparations, and in betel quid (betel leaf, areca nut, slaked lime, condiments and sweeteners, and perhaps tobacco) in various parts of Pakistan and India. It is associated with oral submucous fibrosis, carcinogenesis and foreign body aspiration in children. Commercially, areca nut is marketed in the form of sweetened areca nut (locally known as supari) to target young children.

METHODOLOGY AND RESULTS: The prevalence of areca nut chewing among school children was determined in Thata, Badin, Mirpur Khas and Tharparkar districts of rural Sindh, Pakistan. Trained physicians examined children and obtained information about the use of areca nut. Children were also examined for weight and height, and other information was obtained through a questionnaire. Z-scores of less than -2 standard deviation were used to define wasting and stunting in relation to the median of National Center for Health Statistics and Center for Disease Control (NCHS/CDC) standards. A total of 2,470 children aged 6-12 years were examined in 32 primary schools. Six hundred and sixty-nine children (39 percent) reported use of areca nut in past month. Male children compared to females were more likely to use areca nut (41 percent versus 35 percent, odds ratio (OR) 1.39, 95% confidence interval (CI) 1.17-1.64). Children were more likely to use areca nut if they were wasted (OR 1.53, 95% CI 1.24-1.88) or stunted (OR 1.36, 95% CI 1.10-1.68). Children who reported use of areca nut were more likely to have fathers who worked as laborers (OR 1.30, 95% CI 1.08-1.57).

CONCLUSION: In rural villages of Sindh, Pakistan, a substantial number of primary school children use areca nut.

PARTNERS: Department of Community Health Sciences, the Aga Khan University

ADDITIONAL AUTHOR: Syed M. Shah

Caring for Orphans in the Family Environment

Steven Mutyaba

LEARNING OBJECTIVES: Participants will learn the benefits of raising orphans in the family environment.

BACKGROUND: There were massive numbers of orphans in the war-ravaged areas of Uganda. Many of them were subjected to child labor, exposed to child abuse and early sexual relationships with older men.

METHODOLOGY AND RESULTS: Mirembe, a faith-based local NGO, wanted to assist the orphans; due to limited resources, they preferred caring for these orphans in the family environment. Mirembe worked with the community of women living with HIV/AIDS and some AIDS service organizations. Through the local leaders, families in the community willing to take the orphans would come and sign a memorandum of understanding with Mirembe in the presence of the community leaders. The family members were trained in preventive and curative services for the most common life-threatening childhood diseases, child rights and the benefits of a healthy environment. There had to be a health unit, nursery and primary school in the communities where children were cared for.

CONCLUSION: Raising orphans in the family environment is cost-effective; the community has a share in taking care of its future generation; children/orphans get parental guidance they would have missed and their basic needs are addressed to an acceptable standard. Evaluation after five years showed that from March 1991 to March 1993, 26 children aged 2 months to 6 years were adopted in this way. Between 1994 and 1996, 22 children in that same age range and seven more children aged between 7 and 11 years were adopted. From March 1991 to March 1996, 55 children were orphaned in different families. These children's health has been safe wherever they have been cared for. They have been able to attend the universal education program, gained life skills and have retained their culture.

PARTNERS: Mugga Family Project, Mirembe Helper Project

Gaps Analysis to Identify Key Family Practices and Behavior Change Strategy Interventions in Community IMCI for Ndwedwe, South Africa

Farshid Meidany

LEARNING OBJECTIVES: Participants will be able to use gaps analysis methodology for identifying key family practices and behavior change strategy (BCS) interventions in their respective project fields.

BACKGROUND: The Integrated Management of Childhood Illnesses (IMCI) key family practices gaps analysis is a qualitative baseline assessment of household and community practices that may be carried out in preparation for the introduction of the community component of IMCI. The IMCI community component complements the facility and health system components of IMCI. It is aimed at initiating, reinforcing and sustaining family practices that foster child survival, growth and development. A gaps analysis instrument was developed and realized in August 2002 for the Ndwedwe District Child Survival Project (NDSCP) in Kwazulu Natal, South Africa based on the key family practices identified as essential to the health of children by the South African Department of Health on the basis of guidelines from WHO and UNICEF. The key family practices are those household behaviors that, if followed systematically, can improve child survival rates and protect children against preventable diseases. The purpose of the gaps analysis is to provide an assessment, based on discussions with community members, of the degree to which household and community practices match the ideal behaviors described by the key family practices. The results of this qualitative search were later used in a group discussion/workshop comprising the communities, district health and NDCSP to identify key BCS interventions.

CONCLUSION: The gaps analysis can be utilized as a simple tool to identify program priorities by scoring each key family practice in terms of whether all, most, some, few or none of the members of the community currently practice it and later identify the most appropriate BCS community interventions.

PARTNERS: Project staff, district health management team, Ndwedwe community

ADDITIONAL AUTHORS: Barbara Parker, Dennis Cherian, June Kelly, Joseph Carter

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SOCIAL ENVIRONMENT AND HEALTH: CHILD AND ADOLESCENT HEALTH

Perinatal Care Status in Egypt

Lamiaa Mohsen

LEARNING OBJECTIVES: Each participant will be able to understand the magnitude and determinants of perinatal/neonatal mortality in Egypt, and identify the interventions implemented during the perinatal program in Egypt, lessons learned and next steps.

BACKGROUND: Perinatal and neonatal mortality is most effectively addressed by interventions in pregnancy, during labor and delivery, and in the first few weeks after birth. Most perinatal deaths are caused by infectious diseases such as sepsis and pneumonia, pregnancy-related complications such as placenta previa, and delivery-related complications such as premature birth, intrapartum asphyxia and birth trauma. Moreover, the majority of these factors are avoidable. The perinatal care program in Egypt systematically focused on these avoidable factors using an integrated approach that included technical, policy and management interventions at all levels of the system to reduce both maternal and neonatal mortality. Maternal mortality in Egypt has declined to 84/100,000 in the year 2000 and neonatal mortality to 24/1,000. Interventions included intensive training for OB/GYN and neonatal specialists, IEC (information, education, communication) in the community and renovation of neonatal care units.

CONCLUSION: Perinatal and neonatal mortality were addressed by consolidating efforts toward an interface between neonatal and obstetric services through ensuring the quality of integrated perinatal services in the obstetric environment, developing specific indicators that will monitor the practice as well as encouraging hospital- and district-based activities.

PARTNERS: Healthy Mother/Healthy Child Project staff, Ministry of Health and Population, university medical school and nursing school faculties, George Washington University

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SOCIAL ENVIRONMENT AND HEALTH: CHILD AND ADOLESCENT HEALTH

Race Differences in the Diagnosis of Autism

Jennifer Pinto-Martin

LEARNING OBJECTIVES: Participants will be able to understand the variation by race in the age at which children first receive a diagnosis of autistic spectrum disorder (ASD), and the time spent in the mental health system before the ASD diagnosis is given.

BACKGROUND: Autism is an often-disabling disorder affecting 1-2 per 1,000 individuals. Research suggests that the earlier children enter treatment, the better their outcomes. To this end, instruments have been developed that can successfully screen for ASD in children as young as 18 months. In spite of the availability of this early screen, the mean age of diagnosis is six years. Recent epidemiologic studies suggest that there are no differences by race, ethnicity or socioeconomic status in the prevalence or incidence of autism. On the other hand, research suggests that there are significant racial differences in practice regarding the assignation of psychiatric diagnoses, use of mental health services and treatment. African-American youth are less likely to seek and use mental health treatment. Once in treatment, they receive different diagnoses at different rates than white youth. For a number of disorders, African-American youth may also be undertreated compared with white youth. While these issues have been studied among children with conduct-related, psychotic and depressive disorders, they have not been studied among children with autism.

METHODOLOGY AND RESULTS: Using Medicaid mental health claims from Philadelphia, Pennsylvania, 406 children were identified who received services in 1999 related to a diagnosis of ASD. Medicaid claims from 1993 to 1999 were then used to identify the date that children had their first specialty mental health visit, the date they first received an ASD diagnosis, and the number of visits that occurred between those two dates. Cumulative frequency tables and linear regression were used to examine the relationship among race, age at first diagnosis of autistic spectrum disorder, time in mental health treatment and number of visits until the diagnosis was made. Unstructured interviews with families of autistic children conducted as part of a previous, related study were used to help interpret the results of these analyses. On average, white children were first diagnosed with autism at 6.3 years of age, compared with 7.9 years for African-American children ($P<0.001$). White children entered the mental health system at an earlier age (6.0 versus 7.1 years). African-American children had an average of 13 visits over 10 months before a diagnosis of ASD was made, compared with four visits over four months for white children.

CONCLUSION: The results of this study suggest that large and important racial disparities exist in the early detection and treatment of ASD. These disparities may be the result of differences in help-seeking, advocacy and support, and clinician behaviors. Interviews with families suggested that clinicians are often reluctant to give an ASD diagnosis and may do so only at the urging of family members. A mixed methods study is proposed to identify factors associated with these findings, including family, clinician and social network characteristics.

PARTNERS: Center for Mental Health Policy and Services Research, University of Pennsylvania Hospital (University of Pennsylvania), Children's Hospital of Philadelphia

ADDITIONAL AUTHORS: David S. Mandell, John Listerud, Susan E. Levy

POSTERS

SOCIAL ENVIRONMENT AND HEALTH: CHILD AND ADOLESCENT HEALTH

Unexplained Infant Deaths and Thwarted Female Feticides

Jacob Puliyel

LEARNING OBJECTIVES: Participants will learn how gender bias can be exposed by looking at causes of infant mortality in the two genders.

BACKGROUND: There are only 933 females per 1,000 males in India. Gender discrimination is implicated. Efforts have been made to alter the adverse gender ratio by banning antenatal sex determination and selective feticide. The causes of infant death of girls were compared against that of the boys. It was hypothesized that if there is gender bias, discrimination and neglect, there should be an increase in deaths in the neglected gender due to causes that would not be fatal with appropriate care, whereas the death rate for diseases with grave prognosis would be equal in both the genders.

METHODOLOGY AND RESULTS: Analysis of results of a verbal autopsy to look at cause-specific infant mortality rate among males and females over a five-year period in a community health project area, covering a population of 75,000 persons. The gender ratio at birth for the period was 869 females per 1,000 males. There were 442 deaths for children under one year, and 53 percent were girls. The mean infant mortality rate for girls was 1.3 times that of the boys ($P<0.05$). Diarrhea was responsible for 21.5 percent of deaths. Twice as many girls died due to diarrhea than boys. No significant difference in deaths was seen for causes such as birth asphyxia, septicemia, prematurity and congenital anomalies. In 10 percent of the deaths, there was no preceding illness and no satisfactory cause found. Three out of four such deaths without satisfactory explanation were girls. There is a growing volume of literature from developed countries to suggest that some sudden infant death syndrome (SIDS) may be a covert form of fatal child abuse. We wonder if some of these deaths without sufficient explanation may be due to foul play. With selective feticide banned by law in India, we speculate there will be an increase in numbers of such unexplained deaths in girls in infancy.

CONCLUSION: Gender bias, neglect of girls and sometimes death under suspicious circumstances are common in this community.

PARTNERS: Project staff of community health project at St. Stephens Hospital

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SOCIAL ENVIRONMENT AND HEALTH: ADOLESCENT REPRODUCTIVE HEALTH

Adolescent Health Education Program: Changes in Attitude toward Sexually Transmitted Diseases/AIDS

Sahariar Mostaque Hossain

LEARNING OBJECTIVES: Participants attending the session will be able to identify the positive impact of a health education program on adolescents knowledge, attitude and practice on sexually transmitted disease (STD)/AIDS.

BACKGROUND: A qualitative study among adolescents was conducted in the slum area of Norshingdee district in Bangladesh in 2002. The subjects were mostly Muslim and never disclosed their problems regarding sexual and reproductive health (SRH), living with poor facilities of drinking water, sanitation, education, health care and housing. The study also revealed that they had limited knowledge on primary and secondary sexual character, STDs/HIV/AIDS and human reproduction, but some were involved in premarital and extramarital sexual relationships, or sexual coercion in the workplace and home area. The project revealed how adolescents were vulnerable to STDs/AIDS and how they realize the need for education and information on SRH. The project, in its second phase, included family life education for 160 boys and 160 girls, conducted in four groups to make them motivated and educated in informal group discussion using flip charts, posters, comics, games and graffiti. Similar to behavior change communication, the interpersonal communication was done by two facilitators (one for males and one for females). The suspected cases then underwent some pathological examinations and treatment.

METHODOLOGY AND RESULTS: The adolescents' shyness altered into frankness and their conservative attitude turned into freedom as they become aware of their own bodies and minds regarding sexuality and reproduction. They showed keen interest in participating openly. They sounded their inner voices. Among 320 subjects, 34 adolescents (10.62 percent) acknowledged that they had had sexual experience with the opposite sex. Twenty-seven (8.43 percent) were found with STDs; 19 (70.3 percent) were male and eight (29.6 percent) were female. The specific diseases were gonorrhea in nine (seven boys, two girls), syphilis in one boy, scabies of genitalia in seven (five boys, two girls), nonspecific urethritis in seven (six boys, one girl) and candidacies in three girls.

CONCLUSION: The health and sex education program was found to be very effective in replacing conservativeness of adolescents with frankness and in building awareness about responsible sexual behavior and seeking health care in the proper time to prevent unwanted pregnancy, unsafe abortion, STDs/HIV/AIDS and other complications, and to promote safe sex for achieving good health.

PARTNER: M.A. Quader

ADDITIONAL AUTHOR: Parvez Sohel Hossain

SOCIAL ENVIRONMENT AND HEALTH: ADOLESCENT REPRODUCTIVE HEALTH

Effect of Family Environment on Premarital Sexual Behavior among Adolescents in Bangladesh

Sadia D. Parveen

LEARNING OBJECTIVES: Participants will be able to perceive the overall need for stronger adolescent reproductive health programs that link information, education and clinical services at all levels of the society, in the cultural context of Southeast Asia, where discussions with young people on sexual and reproductive health (SRH) are taboo. The participants will also learn the need for linking adolescent RH programs to social issues such as women's status and roles in the family and its important contribution to building a healthy generation for the future, particularly in light of the global HIV/AIDS epidemic.

BACKGROUND: Little is known about the SRH status of adolescents in Bangladesh. Only recently, in the post-ICPD (International Conference on Population and Development) period, has this group received attention and recognition as being vulnerable regarding their RH status. It is therefore important to identify the different factors influencing adolescents' sexual behavior at different levels and to design strategies appropriate for each. This study aimed to assess the effect of the family environment on the sexual behavior of adolescents.

METHODOLOGY AND RESULTS: The study used secondary data from the 1996 Adolescent Survey of Population Council, Bangladesh. Life tables and Cox's regression models were used to assess extent of premarital sex prevailing in the study population and factors related to this. A total of 1,860 respondents were interviewed, of whom one-third were urban and two-thirds rural. Among them, 33.5 percent were married female adolescents aged 15-19 years and 32.2 percent were their husbands. The unmarried male and female adolescents comprised 16.1 and 18.2 percent of the survey population, respectively. The mean age of both male and female adolescents was 17 years, while that of the husbands of married adolescents was 26 years.

CONCLUSION: More than one-third of respondents stated that they had had premarital sex (almost one-half of the male adolescents and one-tenth of the females). The probability of having premarital sex gradually increased with age. It was highest at age 15 years for both sexes. The median survival time for having premarital sex was 18 and 20 years for the males and females, respectively. Knowledge about reproductive health issues, area of residence and a woman's status in the family were significantly related to an adolescent's likelihood of having premarital sex. In general, respondents with higher knowledge about sexually transmitted disease and reproductive tract infection were more likely to have reported having had premarital sex, as were those living in urban areas and those who lived in households where the woman's status was low. The findings strongly indicate the need for design and implementation of appropriate SRH programs and strategies focusing on adolescents and involving the community and school, as well as adolescents to convey the correct information to them in this regard.

SOCIAL ENVIRONMENT AND HEALTH: ADOLESCENT REPRODUCTIVE HEALTH

Impact of a Community-Based Adolescent Health Campaign

Carol Sienche

POSTERS

LEARNING OBJECTIVES: Participants will understand the conceptualization, implementation and impact of a community-based multimedia campaign in Guinea, West Africa that sought to reduce the spread of HIV/AIDS and unintended pregnancies among young people.

BACKGROUND: The campaign goal was to help to influence social norms and equip young people with the knowledge and skills they need to discuss issues related to sexuality and HIV/AIDS prevention, and practice abstinence or use condoms to decrease HIV/AIDS and unintended pregnancies. The campaign themes were: 1) to reach, engage and mobilize youth with the information and skills they need to protect themselves and their friends from HIV infection and unintended pregnancies; 2) to increase community-wide dialogue about HIV/AIDS and strengthen social support for discussion of sexuality, including HIV/AIDS and pregnancy prevention measures through the 'Break the Silence' approach; and 3) to raise not fear but rather a sense of vulnerability. The key interventions were peer education training, counseling and outreach activities to strengthen young persons' capacity, youth enter-education interventions to give youth a voice and facilitate behavior change, and community-based interventions to mobilize and involve the community to impact youth behaviors.

METHODOLOGY AND RESULTS: A quasi-experimental design was used to allow comparison of key variables between intervention and control areas, and intervention and demographic and health survey (DHS) 1999 data. Cross-sectional data were collected from a representative household sample of 908 young adults (454 males, 454 females) aged 16-24 years from the intervention regions in Haute Guinea. Data for a control area were collected in a similar manner from a comparable group of youth (49 males and 51 females) in the region of Guinea Forestiere, where project activities were not implemented.

CONCLUSION: The success we experienced is unprecedented in other African countries, and we have many suggestions for replication in other settings. Results show that condom use at last sex was significantly higher ($P<0.01$) among youth in the intervention area compared to the control area (24.1 percent of the males, 2.7 percent of the females), and to the DHS 1999 results for Haute Guinea for this age group (24 percent of males, 2.3 percent of females). Results also show significant differences in perception of community openness to discuss youth sexuality issues, knowledge of condom use for dual protection was significantly higher ($P<0.01$) for the intervention area, and a significant association ($P<0.01$) between level of campaign exposure and condom use at last sex. On the other hand, we also found that once a respondent had participated in two campaign activities, there was a 'diminishing return' effect on behavior change associated with participation in larger number of activities.

PARTNERS: Management Sciences for Health, regional IEC groups, youth groups, schools and local businesses in Guinea, CERREGUI

ADDITIONAL AUTHORS: Guillaume Bakadi, Kim Seifert, Fannie Fonseca-Becker, Winnie Mwebesa, Amiata Kaba, Mohamed Cisse, Denise Haba

A Qualitative Study of the Barriers to Sexual Health for Internally Displaced Young People in Freetown, Sierra Leone

Rachel Partridge

LEARNING OBJECTIVES: Participants will gain an insight into the key barriers to accessing sexual and reproductive health (SRH) information and services for young people living in the internally displaced people (IDP) camps of Freetown, Sierra Leone.

BACKGROUND: The West Africa region, including Sierra Leone, has been particularly affected by massive population movements triggered by years of civil unrest. As a consequence, many thousands of people are living in temporary IDP and refugee camps, and the health facilities available to them are either non-existent or severely constrained. The situation has led to the SRH of the displaced population being compromised, particularly among young people. The aim of this collaborative study with Marie Stopes International was to gain an understanding of the SRH service needs of the young people in the IDP camps of Freetown, Sierra Leone, in order to initiate improvement of the sexual health services and information available to young people.

METHODOLOGY AND RESULTS: This study used qualitative methods to gain information from both the young IDP and key 'gatekeepers,' such as camp officials and service providers, in the camps in Freetown. Four focus group discussions (FGDs) were carried out in five separate camps among young men and women aged 10-14 and 15-20 years. In addition, 24 in-depth interviews were conducted with camp leaders, teachers and health-service providers. The transcripts of both the FGDs and interviews were translated from Krio into English and have been analyzed using horizontal and vertical thematic analysis. This paper presents the findings of the analysis of the FGD data. The participants were asked to discuss why they thought many young people do not access sexual health services. The responses highlighted barriers to young people accessing good SRH information and services in IDP camps of Freetown and shows that they operate at a variety of levels, ranging from the individual level, such as lack of awareness of health services or understanding of sexual health issues, to structural level issues, such as inconvenient opening times, location of services or attitudes of staff. The data also reveal the social and contextual factors, such as poverty and community values, that lead to many young people compromising their sexual and reproductive health.

CONCLUSION: Many young people face a variety of barriers to accessing SRH information and services, which in turn may serve to compromise their SRH. These barriers are present at a range of levels from the individual to the structural and contextual. Although many useful practical suggestions were made by the young people on how to improve the accessibility and acceptability of SRH information and services, it is increasingly obvious that the improvement of the SRH of young people is not only a matter of concern for health-service providers but also for a wide range of actors working in the IDP camps.

PARTNERS: Marie Stopes International, Marie Stopes Society Sierra Leone

ADDITIONAL AUTHORS: Pamela Greene, Roger Ingham

Slum Residence and Sexual Health of Adolescents: Evidence from Poor Urban Neighborhoods in Ibadan, Nigeria

Jagha Temple Oritsegbubemi

LEARNING OBJECTIVES: Participants will have gained insight into some of the key sexual health issues facing young people living in the slums of Ibadan, Nigeria.

BACKGROUND: The sexual health of adolescents in the urban slums of Ibadan, Nigeria is extremely sensitive to the worsening economic conditions. In view of this situation, sexual activity has become a survival strategy given the increasing hardship, poverty, unemployment, reductions in income-earning opportunities, school dropouts and other aspects of marginalization. These negatively affect adolescents, especially girls, thus reducing the age at first sex and increasing the incidence of multiple partnerships.

METHODOLOGY AND RESULTS: Qualitative and quantitative data were generated in eight slum communities in two local government areas of Ibadan, the largest metropolis in West Africa. Participatory learning and action methodology, consisting of nonverbal tools and focus group discussions were used in generating qualitative data. Results from this informed the design of a questionnaire, which was then administered in a household survey to a sample of 1,600 adolescents equally divided between males and females aged between 15-19 and 20-24 years, and selected using a combination of cluster and systematic sampling techniques. The results indicate that one in three adolescent slum residents commence sexual relations before age 15 and by age 19, 75 percent are sexually active. Of these, about 34 percent engage in sex as a result of economic pressures. Social and environmental factors, such as overcrowded living conditions, education and religion, were also identified as contributing to the rate of sexual activities among respondents. In addition to this is the phenomenon of multiple partnerships in which case 35 percent of those sexually active had 2-4 partners in the 30 days preceding the survey. Despite the high rates of sexual activities and multiple partnerships, there is a low level of risk perception and preventive behavior.

CONCLUSION: The findings of the study show that slum residence significantly influences sexual behavior among adolescents. The social, economic and environmental conditions under which they live influence them to initiate sexual activity at lower ages and to have multiple sexual partners. The low levels of risk perception, lack of preventive measures and absence of facilities to enhance the sexual health of young people have grave implications for the overall condition of adolescents in the era of HIV/AIDS.

PARTNERS: University of Ibadan, University of Southampton, Association for Reproductive and Family Health

ADDITIONAL AUTHORS: Adebola Adedimeji, Rachel Partridge, Roger Ingham, Nyovani Madise

SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

Alcohol-Related Violence: Women's Experiences in Rural India

Lynette J. Menezes

LEARNING OBJECTIVES: Participants will be able to recognize how rural women perceive marital violence and discuss the role of alcohol in the perpetration of this violence.

BACKGROUND: The limited published research in India reveals that marital violence is a common phenomenon. However, little is known about violence against rural women. Using a social constructionist perspective and an ethnographic qualitative design, this study seeks to understand how rural women, health-care providers and women police officers in Central India perceive and define violence during pregnancy and at other times.

METHODOLOGY AND RESULTS: Utilizing a quota sampling strategy, married women of child-bearing age attending antenatal, maternal and child health and outpatient clinics from five primary health care centers and one rural hospital were recruited for this study. Tape-recorded in-depth unstructured interviews were conducted with 43 women, 12 antenatal midwives (ANMs), seven physicians and four women police. Additionally, three focus group interviews were conducted with women. Ethnographic analysis highlighted the native terminology used by women to identify different forms of violence perpetrated by the husband. Women did not construe violence as a physical, psychological or sexual act but rather as a continuum of severe to minor acts that are harmful to daily living. More than one-third of the respondents reported experiencing some form of violence at least once in their lifetime. Two-thirds of the abused women expressed that violence during pregnancy and at other times was related to the excessive drinking behavior of their husbands. Most of the alcoholic husbands had also injured their wives. Overall, the majority of non-abused women, focus groups participants, physicians and ANMs reiterated that men who drink excessively abuse their wives and sometimes children, and provided several examples of alcohol-related abuse. Community members failed to intervene because of the common perception that violence is a normal part of alcoholic behavior.

CONCLUSION: Ethnographic research provides a rich context to the violence that rural women encounter daily. Screening for violence in primary health care centers is essential and must include women's terminology instead of traditional terms for violence. Interventions should also focus on the role of alcohol in abusive behavior.

ADDITIONAL AUTHOR: Martha Coulter

SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

A Community–Based Approach to Monitoring and Evaluation that Improves Maternal Health Outcomes

Cynthie Tin-Oo

LEARNING OBJECTIVES: Participants will be able to list two ways that monitoring/evaluation can be used to improve community-based safe motherhood interventions.

BACKGROUND: In 2000, Save the Children (SC) began a reproductive health project in a rural region of Myanmar with a high maternal mortality ratio, untrained traditional birth attendants, and limited knowledge of and access to emergency obstetric care and contraceptives. SC developed, tested and evaluated a community-based monitoring and evaluation system that used a pregnancy/delivery card and eligible couple registry for training, as reminders, and to monitor and evaluate progress toward achieving reproductive health objectives.

CONCLUSION: The villagers gained the ability to measure their own safe motherhood activities and knowledge using the tools they developed together with SC. Monitoring and evaluation has shown increased antenatal care, improved delivery practices and more appropriate postpartum care and contraceptive usage. SC believes it has developed user-friendly monitoring tools for villagers to monitor reproductive health activities. These tools measure the outcomes of program activities and promote strengthening and modification of interventions to improve outcomes. The approach is being replicated in other community-based health programs.

PARTNERS: Community groups at the village level, Department of Health staff

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POSTERS

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SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

Developing National Information, Education and Communication Campaigns to Improve Maternal Health in Egypt

Christopher McDermott

LEARNING OBJECTIVES: Participants will be able to identify effective social marketing techniques used in Egypt to reach audiences by employing social campaigns to ensure reach, recall and retention of key messages.

BACKGROUND: The USAID-funded Healthy Mother/Healthy Child (HM/HC) Project in Egypt designed an IEC (information, education, communication) strategy to create demand for quality maternal and child health (MCH) services and promote healthy household behaviors to improve the health of mothers and young children. The activities developed based on this strategy targeted both the community and health-care providers and emphasized promotion of the MCH package of essential services. The HM/HC Project social marketing campaigns relied on the combination of scientific field research, both qualitative and quantitative, with the best creative talent. One objective of the HM/HC social campaigns was to mobilize the creative resources of the private sector in Egypt to work together to achieve the HM/HC goals. Choosing the campaign theme(s) was a carefully weighed process between needs and receptivity of the target group. Additionally, qualitative research helped to identify the contextual framework about women and their families, their motivations, fears, hopes, barriers and resistances that clearly defined their behaviors. Two HM/HC national IEC campaigns on birth preparedness and caring for mother and baby were developed, implemented, launched and evaluated. The birth preparedness campaign emphasized important behaviors for the pregnant woman, her family and household, including support for essential antenatal care, ensuring clean and safe delivery, recognition-seeking of obstetric and neonatal danger signs and prompt care-seeking, and immediate and exclusive breastfeeding. The caring for mother and baby campaign emphasized important behaviors for mothers, their newborns, their families and health personnel, including postpartum and neonatal care as essential preventive care, early recognition of postpartum and neonatal danger signs and prompt care.

CONCLUSION: Lessons learned in the implementation of the HM/HC IEC strategy include the following: 1) clearly understand the barriers and motivations of the target audience to achieve ideal behaviors; 2) combine scientific field research, both qualitative and quantitative, with the best creative talent; 3) integrate communication efforts; 4) listen carefully to potential audience groups; 5) utilize independent monitoring and evaluation; 6) identify and collaborate with key partners; 7) build capacity to sustain IEC activities; and 8) train providers in interpersonal communication.

PARTNERS: Ministry of Health and Population, Egypt, USAID, John Snow, Inc.

ADDITIONAL AUTHORS: Reginald Gipson, Marcia Griffiths

SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

Maternal Mortality Trend in Egypt 1992-2000

Alaa Sultan

LEARNING OBJECTIVES: Participants attending this session will be able to assess the remarkable decline in the maternal mortality ratio (MMR) in Egypt, and identify the causes/interventions leading to the dramatic decline.

BACKGROUND: Maternal morbidity and mortality is the leading cause of ill health in women of reproductive age. It is responsible for 18 percent of the global disease burden of women aged 15-44 years, the majority of which occurs in low-income countries.

METHODOLOGY AND RESULTS: This study compares the MMR from two national surveys in Egypt: 1992-1993 and 2000. Regional differences are elicited and causes/interventions associated with the change in maternal mortality are identified. Egypt's MMR declined significantly between 1992-1993 and 2000, from 174/100,000 live births to 84/100,000. The study design of the two national surveys is similar; the only difference is that all governorates (n=27) were included in the 2000 survey whereas 21 were included in the 1992-1993 survey. In 1992-1993, maternal mortality was 39 percent higher in Upper Egypt (UE) than in Lower Egypt (LE). By 2000, MMR declined in both regions, but to a greater extent in UE. MMR was reduced from 233/100,000 live births to 48/100,000 in metropolitan Egypt, from 217 to 89 in UE and from 132 to 93 in LE. Determinants of this change are discussed. Since 1992-1993, the government of Egypt and donors have made considerable progress in areas that prevent maternal death: family planning and access to skilled pregnancy and delivery care. During the study period, the contraceptive prevalence rate rose from 45 percent to 54 percent, the total fertility rate declined from 3.9 to 3.5 and the institutional delivery rate increased tremendously from 27 percent to 48 percent. For most indicators, the magnitude and percentage of change were greater in UE than in LE. While rates of contraceptive use, antenatal care utilization and skilled delivery care remain lower in UE, due to recent efforts the rates have improved faster in UE than in LE.

CONCLUSION: Egypt has made considerable progress in areas that prevent maternal death: family planning, antenatal care and access to skilled delivery care. UE's greater reduction in maternal mortality may be attributable to increased supply and quality of obstetric care.

PARTNERS: Ministry of Health and Population, Egypt, USAID, John Snow, Inc.

ADDITIONAL AUTHORS: Oona M. R. Campbell, Reginald Gipson, Adel Hakim Issa, Nahed Matta, Bothina El Deeb

SOCIAL ENVIRONMENT AND HEALTH: HEALTH SYSTEMS

Strengthening Pre-service Midwifery Education in Ghana

Abigail Kyei

LEARNING OBJECTIVES: Participants will be able to describe a process used to strengthen pre-service education of nurse-midwives, and the effectiveness of this process as applied in Ghana.

BACKGROUND: To address primary health and prevention needs of the population in Ghana, the government of Ghana made it a priority to ensure availability of skilled midwives in both urban and rural settings. Recognizing that pre-service education of midwives is a sustainable, effective means to ensure that midwives graduate with necessary skills, they requested that JHPIEGO provide technical assistance to strengthen reproductive and maternal health education at 12 midwifery schools. In Ghana, JHPIEGO drew on a considerable body of experience in strengthening pre-service education, described in JHPIEGO's *Preservice Implementation Guide*. The process described in this guide seeks to update technical content while also incorporating mastery learning and competency-based training into the pre-service system. This process also recognizes that the pre-service system is composed of multiple elements, beginning with but not limited to the school itself. Implementation of this process in Ghana used a phased approach: Phase 1 targeted two schools and Phase 2 an additional three schools. Currently, JHPIEGO is implementing Phase 3 at the remaining seven midwifery schools. This phased approach allows for lessons learned in each phase to shape expansion in the next one. In May 2002, JHPIEGO compared reproductive and maternal health knowledge and skills of 72 midwives who graduated in 2000 from JHPIEGO-assisted schools with 70 midwives graduating the same year from schools that were not yet part of the program. Results showed that midwives from JHPIEGO-assisted schools had significantly higher scores for overall knowledge and key clinical skills, including family planning counseling.

CONCLUSION: Two years after graduation, midwives trained at schools using updated training methods and materials were more knowledgeable and skillful compared to midwives trained in other schools. These findings suggest that JHPIEGO's approach to strengthening pre-service education can effectively produce better-prepared midwives and should be adapted and adopted in other countries.

PARTNERS: Ministry of Health, Nurses-Midwives Council

ADDITIONAL AUTHORS: Susi Wyss, Kai Spratt, Linda Fogarty, Lois Schaefer

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SOCIAL ENVIRONMENT AND HEALTH: HEALTH SYSTEMS

Supportive Supervision for Auxiliary Nurse-Midwives in Uttar Pradesh, India

Brijendra Singh

LEARNING OBJECTIVES: Participants will be able to articulate the concept of supportive supervision and explain how the strategy is being applied to reinforce the knowledge and skills of an important cadre of primary providers in India.

BACKGROUND: The PRIME II Project is providing technical assistance to a training program in clinical family planning services for auxiliary nurse-midwives (ANMs) and their supervisors, the lady health visitors (LHVs), in Uttar Pradesh, India, under the Innovations in Family Planning Services (IFPS) Project funded by USAID. Each ANM typically serves 1,000 women of childbearing age from her village subcenter. The training aims to improve the providers' overall performance and enable them to deliver quality family planning services that include increased method mix and updated skills in intra-uterine device (IUD) insertion and removal. Recognizing that post-training support is essential for sustaining better performance, the training emphasizes supportive supervision, interpreted as two interactions per month between an LHV and each ANM supervised. Data indicate that the program has met its benchmark indicator (50 percent of LHVs performing supportive supervision) in 14 districts. A recently conducted qualitative study explored the perceptions of the ANMs and LHVs about the supportive supervision strategy.

METHODOLOGY AND RESULTS: Individual in-depth interviews were conducted with 60 ANMs, 13 LHVs and 20 other supervisors in two control and three intervention areas. The results indicate that qualitative changes have taken place in the supervision conducted by trained supervisors. The supervisors are expanding beyond administrative supervision and now emphasize coaching to reinforce clinical knowledge and skills. The ANMs report enhanced levels of support and problem-solving from supervisors, and increased attention is also being paid to quality-related issues, such as counseling and informed choice and following the correct steps, including infection prevention when providing IUD and other services.

CONCLUSION: Data indicate that the increased emphasis on supportive supervision has enhanced supervisory practices and helped improve providers' performance and attitudes. District administrators noting the changes are recommending similar supportive supervision at all levels of the district health service delivery system.

PARTNER: State Innovations in Family Planning Services Agency

ADDITIONAL AUTHORS: Charu Chopra, Maj-Britt Dohlie

SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

Using Qualitative and Quantitative Approaches in a Reproductive Health Program

Khynn Win Win Soe

LEARNING OBJECTIVES: Participants will be able to recognize the advantages of using both quantitative and qualitative research methodologies in a single program intervention.

BACKGROUND: Save the Children implemented a Packard Foundation-funded reproductive health program in Myanmar in 2000. The purpose of the project was to develop, evaluate and replicate a community-based reproductive health model. Quantitative and qualitative research methodologies were used to understand the reproductive health-related local practices and attitudes and to enable monitoring and evaluation of changes.

CONCLUSION: Use of quantitative and qualitative methods can be integrated and incorporated in formative research for health programs. The qualitative study provided depth in the findings and also raised the community's awareness of their reproductive health situations through discussions and interviews. The feedback discussions helped the village communities to realize their current reproductive health situations and possible ways for improvement by mobilizing the community to recognize their own potential for improvement. The qualitative data proved to be sufficient to design an intervention. Because the results from the qualitative study were already available, the quantitative study was designed to illuminate the qualitative findings. The quantitative results supported and confirmed the qualitative findings. Integration of data from different techniques enables validation. The quantitative data determines the measurable baseline situation before the intervention for monitoring and evaluation purposes. Changes in key indicators resulting from the intervention can be measured.

PARTNERS: Myanmar Ministry of Health, Population Services International

ADDITIONAL AUTHORS: Cynthie Tin Oo, Win Win Shein, Nilar, Kyaw Myo Thein, Myint Thu Lwin, Amy Lehr

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SOCIAL ENVIRONMENT AND HEALTH: HIV/AIDS

Advocacy for HIV/AIDS Prevention in Rwanda Prisons

Laurien Nyabienda

LEARNING OBJECTIVES: Participants will be able to appreciate how special environments, such as prisons, can undermine globally accepted prevention strategies.

BACKGROUND: Following the human holocaust that befell Rwanda in 1994, a lot of people accused of genocide were arrested. Today, 8 years later, there are more than 100,000 of such prisoners awaiting trial. It is reliably known that these prisoners engage in unprotected penetrative sex, although this is prohibited. Because of legal technicalities, these prisoners do not receive HIV preventive services, such as condoms. Hence Rwanda prisons may have become a breeding ground for HIV. In a conventional judicial system, trials are done at a very slow pace. In order to speed up the process, traditional courts, known as GACACA, have been set up and are expected to soon release many into the general population, with a potential capacity to further spread HIV. The intervention is aimed at advocating for the prisoners' right to the same preventive measures as the general public. This advocacy is targeting political leaders, law reform makers and prison administrators all over the country.

CONCLUSION: Lessons learned include: 1) prisoners also have the right to be educated about HIV/AIDS; and 2) educating prisoners about HIV/AIDS will help prevent further spread of HIV/AIDS into the general public. Recommendations include the revision of prison regulations that undermine the promotion of global health. The intervention has now acquired a household reputation among all the stakeholders. It is an innovative experience that can be replicated elsewhere.

PARTNER: National Anti-AIDS Commission

ADDITIONAL AUTHORS: Dorothy Bamurange, John Zirimwabagabo

SOCIAL ENVIRONMENT AND HEALTH: HIV/AIDS

Assessing HIV/AIDS Risk Using Qualitative Methods, South Sudan

Basilica Keji

LEARNING OBJECTIVES: Participants will learn: 1) two examples of biological, individual, social and structural HIV/AIDS risk factors; 2) local knowledge of and attitudes toward HIV/AIDS; 3) three groups at high risk of HIV transmission; and 4) three needs of health facilities identified in the assessments.

BACKGROUND: American Rescue Committee/ International Rescue Committee is implementing an 18-month OFDA/USAID pilot project in Yei and Rumbek, South Sudan. Little was known about the dynamics of HIV/AIDS in the region. To plan interventions, assessments were conducted during February-June 2002 identifying biological, individual, social and structural risk factors, high-risk groups and their knowledge, attitudes, and practices, and needs of health facilities in terms of providing quality sexually transmitted infection (STI)/HIV/AIDS services.

METHODOLOGY AND RESULTS: Rapid assessments were conducted using ethnographic research, mapping and site inventories. Behavior change communication (BCC) formative research used focus group discussions, in-depth interviews and participatory learning/action techniques. Health facility assessments included provider interviews, record reviews and observation. The findings included: 1) high rates of STIs and poor STI symptom recognition and treatment-seeking behavior; 2) early sexual initiation; 3) traditional practices involving blood exchange; 4) polygamy, widow inheritance; 5) long-term conflict triggering forced migration, disturbances in community structures/cultural norms, increased gender-based violence, increased sexual mixing within South Sudan and high-prevalence neighboring countries, and decreased accessibility to services; 6) high-risk groups: military, youth, traders, women without male protection, transport, customs and relief workers; 7) condoms rarely used, rarely available; 8) no standardized STI protocols in health facilities, health personnel had little/no training in STI management, counseling or universal precautions; 9) laboratory services were weak or non-existent, drug supplies inconsistent; 10) no family planning; 11) no voluntary counseling and testing (VCT); 11) no syphilis screening for pregnant women; 12) HIV/AIDS efforts limited to general population awareness-raising; 13) discriminatory attitudes toward people living with HIV/AIDS, particularly among military; and 14) communities were eager for more information about HIV/AIDS, improved reproductive health and VCT services.

CONCLUSION: Findings were used to develop an implementation strategy focusing on social mobilization, advocacy with community leaders, BCC with high-risk groups, condom distribution, strengthening STI services, training traditional practitioners in universal precautions, establishing VCT with supporting services, and reinforcing health information systems.

PARTNERS: New Sudan National AIDS Council, Yei And Rumbek County Health Departments, Family Health International, John Snow, Inc., Columbia University

ADDITIONAL AUTHORS: Natalie Kruse, Tekleab Kedamo, Catherine Plewman, Greg Rachu

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SOCIAL ENVIRONMENT AND HEALTH: HIV/AIDS

Co-Factors Relating to Maternity and HIV Status in the Dominican Republic

Katy Yanda

LEARNING OBJECTIVES: Participants will be able to outline and discuss social and cultural factors relating to maternity and HIV status for women in the Dominican Republic.

BACKGROUND: The Caribbean has the second highest prevalence rates of HIV infection after sub-Saharan Africa. The Dominican Republic has the third highest rates in the region, with a national prevalence of approximately 2.5 percent. There were an estimated 61,000 HIV-positive women in the Dominican Republic as of 2001. The majority of these women are in 'serious' relationships and have children or are thinking of having children. Most of them do not know their status. A qualitative study was designed to explore and document social and cultural variables related to maternity and HIV status for HIV-positive women in the Dominican Republic. The objectives of the study were to construct a working model of these variables and to leave a structure to develop a nationally implemented survey. It is the first phase of a multitiered project aimed to improve and expand reproductive health programs working with HIV-positive women.

METHODOLOGY AND RESULTS: The study was organized through REDOVIH+, Network of Persons Living with HIV/AIDS in the Dominican Republic, the Dominican Program to Reduce Vertical Transmission of HIV, and three maternity hospitals in Santo Domingo, from June to August 2002. Four focus groups and 10 in-depth interviews were conducted with 29 HIV-positive women who were pregnant or had given birth within the last year. All focus groups and interviews were recorded and transcribed. Instruments, results and reports were reviewed by REDOVIH+ staff and outside consultants. Results were analyzed around reasons woman want or do not want to have children. Additional variables such as previous knowledge of HIV status, accidental pregnancy, use of birth control and desire for future children were included.

CONCLUSION: The desire to be a mother was a fundamental one for the great majority of the women involved, one that perhaps outweighs HIV status. For almost all of the participants, the desire to be a mother was deeply rooted, influenced on different levels and intensity by partner, family and social factors. Maternity had a highly significant personal and societal value. There was understanding for why a woman would not want children, illustrating an intense social pressure for women who are childless by choice or circumstance. This is essential in considering reproductive choices for HIV-positive women.

PARTNERS: Cesar Castellanos, Dulce Almonte, Laura de la Nuez, Linda Cushman

SOCIAL ENVIRONMENT AND HEALTH: HIV/AIDS

Community-Based AIDS Orphans Care and Support Project: Assessing a Sustainable Approach for Communities that Promote Care and Support for the AIDS Orphans

Nellie Ayuma Luchemo

LEARNING OBJECTIVES: Participants will be able to gain an understanding of the community-based AIDS orphans care and support initiative and be able to recognize the challenges and weaknesses of this initiative of mobilizing community to support AIDS orphans.

BACKGROUND: Community-Based AIDS Orphans Care and Support Project (CBAOCSP) is part of the community-based initiative funded by World Bank through the National AIDS Control Council (NACC) national coordinating body based in the office of the President. This project builds on local efforts to develop an affordable and sustainable model of AIDS orphans care and support that can also be expanded all over Kenya. Sustainability of community resource mobilization for the community-based programs is a major challenge. The CBAOCSP has relied on Maendelo Ya Wanawake Organization (MYWO), a national women's advocacy organization, to organize her leaders and members to sensitize, mobilize and recruit AIDS orphans in surrounding communities to the project using the advocacy and communication process. MYWO leaders encourage communities to join efforts in the care and support of AIDS orphans for sustainability. MYWO believes communities have the potential to care and support the AIDS orphans through day care feeding centers for the orphans, which encourage collective community responsibility. The project is being implemented in Western Kenya in two day care centers. The model being tested is based on the community's own resource mobilization strategy. The community contributes food, clothes and time to the centers. The majority of the community members live below the poverty line but are determined to support the orphans.

CONCLUSION: The community was able to organize themselves to identify the orphans and sites for day care feeding centers, contribute food and develop an action plan to carry out the day care feeding activities. The community hired land where they grow food for the center and have established collaboration with the Ministry of Education to allow orphans to continue with education without being disrupted for nonpayment of school fees and with the Ministry of Health, where the orphans receive services at no cost. Empowering communities through teamwork reduces donor dependancy, enhances program sustainability and encourages responsibility among the communities. The end result has been that the communities have provided basic care to the AIDS orphans in their catchments and thus improved quality of life for the orphans.

PARTNERS: NACC office of the President, Ministry of Health, Ministry of Education, Ministry of Culture and Social Services

ADDITIONAL AUTHORS: Elizabeth Anziya, Margaret Wesonga

SOCIAL ENVIRONMENT AND HEALTH: HIV/AIDS

Community Partnerships to Fight AIDS: Bambisanani

Litha Klaas

LEARNING OBJECTIVES: Participants will learn how partnerships with the private sector, government, NGOs and local communities can enhance care of people living with HIV and children orphaned by HIV.

BACKGROUND: The Bambisanani Project targets three rural sub-districts of the former apartheid-regime homeland of Transkei in South Africa. Among the poorest in the country, this area has few health services available, with only one doctor for every 16,592 people and residents. HIV infection among pregnant women is 22 percent, and only 17 percent of tuberculosis (TB) cases complete the full course of treatment. Further, local men supply 50 percent of South Africa's mine and migrant laborers. When these laborers fall ill, usually from TB and HIV/AIDS, they return home. Their care becomes the responsibility of their families, who have little or no means to support them. Bambisanani works with local chiefs to identify home care supporters to help families caring for terminally ill loved ones. Care for orphaned and vulnerable children and income generation are also key activities. The project is managed by local committees to ensure ownership and sustainability.

CONCLUSION: By mobilizing people to work together and develop local solutions to health challenges, communities are better positioned to confront HIV/AIDS. The lessons learned from the Bambisanani Project can be applied to areas with similar poverty levels. Developing a home-based care system that supports families caring for chronically and terminally ill people is a cost-effective intervention for rural, poor settings. More than 500 terminally ill people with TB and HIV/AIDS have been supported through Bambisanani. A successful referral network between government health services, mining companies and communities demonstrates how agencies from all sectors can work together to achieve common goals. A referral system for orphaned and vulnerable children helps to ensure they continue with schooling and are cared for in their communities. Income-generation training and establishment of drop-in centers address the multiple effects of HIV/AIDS on families.

PARTNERS: The EQUITY Project, Bristol Meyers-Squibb, Gold Fields, Anglo Gold and Harmony Gold Mines, the Eastern Cape Province Department of Health, the Employment Bureau of Africa, the Miners Development Agency, the South Coast Hospice, the University of Port Elizabeth Small Business Development Unit

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SOCIAL ENVIRONMENT AND HEALTH: HIV/AIDS

Effect of a Supportive Environment on Infant Feeding Choices Made by HIV-Infected Women

Victoria Babirye

LEARNING OBJECTIVES: Participants attending this session will be able to assess the effect of a supportive environment on the practice of breastfeeding in HIV-infected women.

BACKGROUND: Women who were enrolled after voluntary counseling and testing in a vitamin A intervention trial to reduce mother-to-child transmission of HIV were eligible for inclusion in this retrospective study. Women were recruited at two antenatal clinics. One of the health centers under Nkumba AIDS Community Initiative has a policy of exclusive breastfeeding following international standards. The other, St. Joseph Health Centre, does not have a supportive environment for exclusive breastfeeding. All of the women received similar enhancement and encouragement on exclusive breastfeeding from the study counselors at both sites.

CONCLUSION: Five hundred and forty women were recruited in this two-year study (1998-2000, 214 at St. Joseph's and 326 at Nkumba.) Baseline characteristics of the women in both places were similar. Of the women, 192 at St. Joseph's and 288 at Nkumbawere were followed up to at least 3 months postpartum. At three months, 150 women at St. Joseph's were breastfeeding while 190 were breastfeeding at Nkumba. Thirty of the 150 women (20 percent) at St. Joseph's breastfed exclusively compared to 92 of 182 (50 percent) at Nkumba. This difference is significant. HIV-infected women who give birth at health centers with a supportive environment for exclusive breastfeeding are more likely to practice exclusive breastfeeding at three months postpartum than others who give birth in similar centers with no exclusive breastfeeding support. Questions regarding HIV transmission through breast milk have been raised. However, given the lack of modern affordable formula, breastfeeding is still encouraged in this resource-limited area.

PARTNERS: Nkumba AIDS Community Initiative, St. Joseph's Health Centre, Maternal and Child Health Program, Ministry of Health

ADDITIONAL AUTHORS: Namazzi Peggy, Kityo M., Navuga R., Nakku R.

SOCIAL ENVIRONMENT AND HEALTH: HIV/AIDS

Grappling with HIV/AIDS Through Expanding Prevention Programs in Health Clinics of NGO Service Delivery Program in Bangladesh: A Prospect for Wider Coverage to Reach High-Risk Populations

A.B.M. Kamrul Ahsan

LEARNING OBJECTIVES: Participants attending this session will be able to understand the HIV/AIDS situation in Bangladesh and the importance of expanding HIV/AIDS prevention programs through existing health centers.

BACKGROUND: The prevalence of HIV in Bangladesh is apparently low, but high-risk behaviors among different groups have been revealed. HIV/AIDS prevalence can be fueled by ignorance, lack of services, poverty, a subordinate role of women in the society and the high level of sexually transmitted disease (STD), which predisposes the individual to HIV infection. Myths and denials and cross-border migration to neighboring countries further aggravated the situation. However, the issue has failed to get the attention and high priority for policymakers, resulting in a faster increase in HIV infection. Bangladesh still has an opportunity to prevent an epidemic if action is taken now. Under the essential service package program of the country's health program, NGO Service Delivery Program (NSDP) supports 41 NGOs operating 280 clinics in both urban and rural areas, which are covering almost 20 percent of the total population of the country, including high-risk groups. One of the NSDP's aims is to strengthen the supported organizations to build up capacity through training and mobilization and expand services to reduce the vulnerability of the communities. The key function of NSDP has been to establish the linkage with vulnerable communities and to address issues in HIV prevention work, including cross-cutting themes such as gender equity, sexuality, human rights violation, etc. Experience has shown that HIV infection can be prevented if one has sufficient access to appropriate information and access to adequate health-care services. Strategy has been taken to intensify clinical services, including treatment of STDs, a behavior change approach for high-risk populations, general awareness with clinical support for the general population and social marketing of condoms. The clinics are not labeled for treatment of STDs; rather the patients step in for other needs and come in contact with the service providers, thereby allowing them to get access to services for sexual health issues.

CONCLUSION: The rising incidence of STDs in the population suggests that current efforts to promote reduction in high-risk behaviors are insufficient. Such high-risk behavior reduction will play an essential role in controlling the incidence of STDs and further reducing chances of HIV infection. Increased efforts should focus not only on STD treatment but also on prevention mechanisms through mobilizing the community, which requires skill building of the service providers as well as the community. Peer-based outreach programs could play a vital role in behavior change of the high-risk community. Enhancing the participation and empowerment of youths is a key strategy in containing the spread of HIV/AIDS.

PARTNERS: Forty-one NGOs working with NSDP

Multisectoral HIV/AIDS Task Force: A Model for Prevention and Mitigation

Dickson Tsamwa

LEARNING OBJECTIVES: Participants attending this session will be able to understand the role of a multisectoral approach in HIV/AIDS control and prevention and its effect on the social environment, both rural and urban, and describe steps taken to mobilize a multisectoral task force at the district level.

BACKGROUND: HIV/AIDS and poverty form a vicious cycle that both impacts and is impacted by all sectors of society (i.e., banking, business, law enforcement, education, health, etc.). This will require a multisectoral effort to break it. The District Task Force (DTF) is one way to operationalize a multisectoral response at the district level. In 1996, Project Concern International (PCI) launched a process to support the formation of multisectoral DTFs in five districts in Zambia (four urban, one rural). The goal was to build district capacity to mobilize resources to support the local governments' efforts in implementing HIV/AIDS interventions. Through a series of district-wide and community stakeholders meetings, three-year joint strategic plans were drawn, with activities centering around education campaigns, treatment of sexually transmitted infections, home-based care services, support to orphans and vulnerable children and voluntary counseling and testing services. The four urban districts are now almost entirely self-supporting and adequately complement the local governments' budgets for HIV/AIDS activities. However, the rural DTF has required more effort to build upon sustainability mechanisms, due to the relative financial, communication and infrastructure disadvantages, as compared to urban districts. This paper analyzes in detail seven steps undertaken to form the DTF as an essential social network for health in the rural district of Nchelenge, including rapid and in-depth assessment of existing activities and partners, collaboration with national and local government bodies, and strategies for addressing sustainability.

CONCLUSION: The DTF approach ensures that the comparative advantages represented by its membership are brought to bear on all HIV/AIDS activities in the district. PCI demonstrates the general cost-benefits of the model; however, more research is needed in this area. DTFs in rural communities need prolonged support. Regular meetings of the DTF are critical to the success of the approach.

PARTNERS: District health management team, other government departments, international NGOs, the community

ADDITIONAL AUTHORS: Jennifer Yourkavitch, K. Siachitema

Supporting and Building Community-Based Response to AIDS: 'The Cooking Pot'

Henry Hudson Luyombya

LEARNING OBJECTIVES: Participants attending this session will be able to learn the different ways in which the AIDS problem is tackled in Uganda. They will learn the less expensive techniques to reach the masses, i.e., through community programs such as those of The AIDS Support Organisation (TASO). People will know the 'success story' of TASO as one of the leading NGOs in Uganda fighting HIV/AIDS and implementing prevention strategies.

BACKGROUND: TASO is a local NGO founded in 1987 to restore hope and to improve the quality of life of people infected and affected by HIV/AIDS, their families and communities. The need to support community-based initiatives has helped in the struggle against HIV/AIDS and in extending TASO services to many people at the grassroots level in order to respond to the AIDS epidemic. This has been made possible by training AIDS community workers and parish AIDS committee members at the grassroots. In September 1990, TASO began a community initiative after it was recognized that many of clients who came for counseling had no follow-up community support. At the same time, TASO was getting requests for training and support from various community groups. Some community members were trying to respond to the problem of HIV/AIDS by initiating care, counseling and educational activities but were receiving no formal training or support. TASO recognized the need to empower people at the local level so that they could begin to tackle the AIDS problem on their own. Presently, TASO Mulago has trained over 450 community volunteers in 11 communities of Seeta Nazigo, Kyanja, Ddundu, Busukuma, Kawempe, Sekiwunga, Mpoma, Mende Kalema, Kira and Gombe. Two new communities have been opened up in Goma and Ntenjeru in Mukono district to carry out basic skills needed for home care, basic counseling and AIDS education and sensitization (350 females and 150 males). TASO has brought services nearer to people. AIDS education and awareness has reached the grassroots level, which has reduced the stigma around the HIV/AIDS epidemic and brought about behavioral change.

CONCLUSION: The community HIV/AIDS initiatives program is 'The Cooking Pot.' The cooking pot is placed on three stones in order for it to cook. The three stones are the community leaders, community residents and TASO. Conclusively, 'The Cooking Pot' as a strategy to involve the community in HIV/AIDS programs has proved successful as it creates continuity and sustainability of the programs, and also makes the community a part of the problem. This has brought about behavioral change and has reduced stigma in communities.

ADDITIONAL AUTHORS: Helen Ekideit, Harriet Nabukalu, Anne Kaddumukasa

SOCIAL ENVIRONMENT AND HEALTH: HIV/AIDS

Women's Perceptions of HIV/AIDS in Northeastern Senegal

Rebecca Perry

LEARNING OBJECTIVES: Participants will be able to identify the perceptions, behaviors and knowledge related to HIV/AIDS of women in Northeastern Senegal who are exposed to migrating populations.

BACKGROUND: Senegal has consistently had low HIV prevalence and incidence rates. According to UNAIDS, the incidence of HIV is below 1 percent (0.5 percent) of the adult population (15-49 years old). Yet, Senegal's success might not last as rates are increasing among the migrant population. Figures published in 2000 showed that the majority of AIDS cases (62 percent) in the Fouta, the northeastern region of Senegal, are among individuals who traveled out of the country for one year or more and returned. Furthermore, the only published HIV/AIDS investigation from this region shows that expatriation is a statistically significant risk for contracting HIV/AIDS.

METHODOLOGY AND RESULTS: Six focus group sessions and 20 in-depth, semi-structured personal interviews were conducted with randomly sampled Fouta women in Matam, a capital city in Northeastern Senegal. Both of these qualitative studies were performed in Fulani, the dominant language in the Fouta, with the help of a native Fulani speaker. The findings are as follows: 1) the majority of Fouta women know about HIV/AIDS and were able to present accurate methods of HIV/AIDS transmission; 2) most Fouta women could provide examples of risky behaviors that can lead to HIV/AIDS infection and among the most commonly mentioned risks was having sex with husbands who were returned migrant workers, while exchanging sex for money or necessities while their husbands worked in other countries was also discussed; 3) although the women interviewed have a high awareness of HIV/AIDS and are fairly knowledgeable about HIV/AIDS transmission and risk behaviors, these women never perceive themselves at risk of contracting or having HIV/AIDS; 4) furthermore, HIV/AIDS's association with 'vagabondage sexuel' (promiscuity) has made the disease a taboo subject to discuss with others, and women feel unable to discuss their HIV/AIDS risks or even reveal their sero-positive status to friends or even sexual partners; and 5) HIV/AIDS protection through abstinence and condom use is restricted to the younger generation, as older women are unable to suggest HIV/AIDS protection mechanisms with their sexual partners for fear of being accused of promiscuity and infidelity. These responses will be combined with current demographic data and relevant HIV/AIDS literature in an effort to triangulate the themes drawn from the qualitative studies and provide a broader context.

CONCLUSION: Accurate personal risk perception, condom use and comfort in discussing HIV/AIDS are problematic for Fouta women. Future HIV/AIDS awareness projects in Matam should focus on strengthening these three areas in an effort to prevent and protect against HIV/AIDS.

ADDITIONAL AUTHOR: Soulemayne Mboup

SOCIAL ENVIRONMENT AND HEALTH: HIV/AIDS

Workplace Best Practices to Improve the Employees' Health

Susan Rachel Basirika

LEARNING OBJECTIVES: Participants will be able to identify the benefits of incorporating HIV/AIDS into the existing company policies.

BACKGROUND: In Uganda, many people living with HIV/AIDS were stigmatized at their workplaces and often lost their jobs, although they were usually able to continue making valuable contributions toward the success of their families and business enterprises. Today, it would be news to hear of a family or a company that has never suffered loss of a member or an employee to HIV/AIDS in Uganda.

METHODOLOGY AND RESULTS: Top management of multinational companies formed a voluntary association, the Uganda Business Council (UBCOA). It encourages more participation of the private sector to an open non-stigmatic environment, health schemes and best practices at the workplace. UBCOA has more than 53 companies whose best practices include mobilization of internal and external resources to sensitize employees and employers on health issues, human rights and training staff to act as peer counselors/educators, and to network and collaborate with other institutions to assist HIV/AIDS-infected employees handle their social and health concerns, especially those related to HIV/AIDS. Mandatory HIV tests are strongly discouraged. Voluntary counseling and testing is encouraged and strict confidentiality is a must. Companies are further required to offer at least basic care facilities, internally and externally. Employees who wish to be open to top management about their HIV results and opt for anti-HIV drugs are given US$100 monthly to buy them. Member companies display a chart of their best practice policy at their workplace. The employees have started reporting to management that they now have peace of mind because they can retain their jobs and access drugs to improve their health. They can deliberate on health issues freely with top management and are able to plan for their families and live with hope and dignity. Some of the employees have initiated health clubs in their home areas.

CONCLUSION: Retaining employees is profitable to enterprises. Workplace best practices offer an enabling environment for behavior change and improve employees' health.

SOCIAL ENVIRONMENT AND HEALTH: INFECTIOUS DISEASE

Ceftazidime and Imipenem for the Treatment of Melioidosis

Daniel Seyoum

LEARNING OBJECTIVES: Participants will understand how results from clinical trials on the use of antimicrobial agents are analyzed for the treatment of melioidosis, and which antimicrobial agents may be used in the treatment of melioidosis based on the results of these clinical trials.

BACKGROUND: Melioidosis, an infection caused by burkholdria pseudomallei, causes acute and chronic pulmonary disease, abscesses of the skin and internal organs, meningitis, brain abscess and cerebritis, and acute fulminant rapidly fatal sepsis. Infection with b. pseudomallei has a high mortality rate. Melioidosis is endemic in some areas of Southeast Asia and the northern part of Australia. It is more common among adults, individuals with diabetes and individuals with chronic renal disease, but it can occur in normal hosts and children. Melioidosis can reactivate years after primary infection and result in chronic or acute life-threatening disease. Due to the increase in travel, the infection may be seen in other parts of the world, and patients may present in non-endemic countries with reactivation melioidosis decades after leaving an endemic region. The recognition of pathogens such as b. pseudomallei is essential for the rapid implementation of appropriate antimicrobial therapy. However, the optimum duration of therapy and choice of antibiotics has not been determined.

METHODOLOGY AND RESULTS: Although ceftazidime and imipenem have been used in some settings for the treatment of melioidosis, they have not been approved by the United States Food and Drug Administration for this indication. Members of the USP drug information expert committees reviewed the published clinical trials and case reports on ceftazidime and imipenem for the treatment of melioidosis, presented to them in the form of evidence tables. The evidence tables were based on evidence ratings. The USP drug information expert committees concluded that both ceftazidime and imipenem were safe and effective for the treatment of melioidosis.

CONCLUSION: The members of USP drug information expert committees recommend that ceftazidime and imipenem may be considered for the treatment of melioidosis caused by b. pseudomallei.

PARTNER: USAID

ADDITIONAL AUTHOR: Nancy Blum

SOCIAL ENVIRONMENT AND HEALTH: INFECTIOUS DISEASE

Promoting Infection Prevention in Low-Resource Settings

Paul Hoedom Sossa

LEARNING OBJECTIVES: Participants attending this session will be able to identify appropriate infection prevention practices promoted by the Family Health and AIDS (FHA) Project in West and Central Africa, and recognize the training materials and job aids developed by the FHA Project.

BACKGROUND: The FHA Project introduced the promotion of appropriate infection prevention practices in low-resource settings in West and Central Africa four years ago. This was in response to the lack of such practices in health centers supported by the project and to mainly reduce the transmission of HIV/AIDS. The practices promoted include correct handwashing, clinical waste management and the promotion of low-cost incinerators, appropriate decontamination procedures, used sharp instruments management including disposal, high-level disinfection procedures and correct sterilization procedures. The FHA/JHPIEGO project developed appropriate infection prevention training materials, including a reference manual, a trainer's guide and a participant's handbook. In addition, the project has also developed various job aids on appropriate instrument decontamination procedures and the management of used sharp materials. These materials are widely distributed throughout the region. The FHA Project has trained key health officials and trainers from eleven countries in West and Central Africa during a regional workshop. These key officials replicate the trainings throughout the region. The same training was provided to medical and paramedical school professors, and the subject matter is being included in their respective curricula.

CONCLUSION: The use of infection prevention practices as promoted by the FHA Project has greatly contributed to the improvement of the quality of health services in the project demonstration countries (Burkina Faso, Cameroon, Côte d'Ivoire and Togo) in addition to other countries in the West and Central Africa region. The progress of the improvement in the quality of services at the sites is reported in quarterly supervision reports. Health officials and providers expressed their satisfaction vis-à-vis the results achieved. FHA receives many requests for technical assistance from other development partners in the region to extend the use of appropriate infection prevention practices to a larger number of health facilities. Introducing infection prevention topics in medical and paramedical curricula in the West and Central African region will help reach many potential health providers.

ADDITIONAL AUTHOR: John Dodji Abodjavou

SOCIAL ENVIRONMENT AND HEALTH: INJURY AND DISABILITY

Disease, Injury and Disability among Displaced in Burundi

Colleen Mone

LEARNING OBJECTIVES: Participants will be able to identify the major causes of disability among refugee and internally displaced populations living in conflict areas in Burundi.

BACKGROUND: Burundi has been torn by a series of ethnic conflicts between its Hutu and Tutsi populations. In 1993 alone, an estimated 150,000 Burundians lost their lives to ethnic violence. There is little or no information available from health officials concerning the health status of the population. Data related to injuries, in particular those sustained during the war, are almost nonexistent. The International Rescue Committee (IRC) is documenting the incidence of and evaluating the medical response to disability-inducing injuries among refugee and internally displaced populations in three provinces in Burundi that are experiencing varying degrees of violent conflict: Muyinga, Makamba and Bujumbura Rural.

METHODOLOGY AND RESULTS: The IRC conducted three population-based surveys in Muyinga, Makamba and Bujumbura Rural provinces. Surveyors interviewed 2,068 people living in 400 households in Muyinga province. Forty clusters of 10 houses were selected using a two-stage sampling design. In Stage 1, clusters were assigned to specific collines, systematically proportional to the estimated population. For Stage 2, random starting points within the selected towns were chosen and the residents of the 10 houses nearest to that point were interviewed. Disability prevalence in the survey population is 7.2 percent (149/2,068). Disease represents the number one cause of disability (46 percent), followed by injuries (18 percent). Out of 30 injuries that induced disability, seven were violence-related. Of the violence-related cases, two were war-related, two were due to domestic violence and three cases were assaults.

CONCLUSION: The leading cause of disability among refugees and displaced persons in Muyinga was disease (46 percent), with over 40 percent of the disease (for example, otitis media, malaria, leprosy, tuberculosis, polio, eye, ear and skin infections) - and therefore the disabilities - being preventable. To effectively reduce the incidence of disabilities within this population, government and nongovernmental agencies should aim to strengthen existing community health systems, with a focus on prevention and early treatment of communicable disease.

ADDITIONAL AUTHOR: Mariana Zantop

SOCIAL ENVIRONMENT AND HEALTH: HEALTH AND HUMAN RIGHTS

Identifying, Supporting and Empowering Community Leaders

Doris Anziani

LEARNING OBJECTIVES: Participants will learn at least four criteria for identifying community leaders in a disenfranchised community and four strategies to support their efforts.

BACKGROUND: Lawrence, Massachusetts is one of the oldest planned industrial communities in the United States, drawing a large immigrant population that is now more that 70 percent Hispanic. Poverty is widespread and severe, ranking the city among the twenty-five poorest in the nation, with an average per capital income of less that $10,000. Environmental health threats are significant. Lead levels in children are nearly three times the state rate, and pediatric asthma rates are the highest in Massachusetts. Lawrence experiences air pollution from three solid waste incinerators in a 4.5 square mile area and emissions from multiple manufacturing facilities. Previous activities to address these environmental health issues have been largely organized by non-Hispanic activists and have not engaged the most affected Hispanic community.

METHODOLOGY AND RESULTS: Casa de salud as a model for engaging community is an outreach and education effort designed to engage Hispanic residents of highly stressed neighborhoods of Lawrence to identify and address the health impacts of environmental exposures. To engage the Hispanic community, project partners identified neighborhood leaders and taught them to organize and facilitate meetings in their homes. Monthly training sessions introduced culturally appropriate environmental health educational material for casa leaders to share with friends and neighbors, and to use in planning environmental health interventions.

CONCLUSION: Well-trained community residents can serve as neighborhood leaders to disseminate environmental health information and plan interventions for hard-to-reach populations. Training and supporting community residents to share information in a culturally appropriate setting fosters greater participation by residents in mitigating environmental health threats. Engaging the community in a setting where neighborhood culture is dominant increases the effectiveness of educational initiatives.

PARTNERS: John Snow, Inc. Center for Environmental Health Studies, Greater Lawrence Family Health Center, Family Service, Inc. and Lawrence Environmental Justice Council, Teen Coalition

ADDITIONAL AUTHOR: Serena Dee

LEARNING OBJECTIVES: Participants attending this session will be able to understand how Israel's water distribution system is contributing to a public health catastrophe in the Occupied Territories. Policy-makers, activists and health-care workers will be encouraged to discuss and promote key talking points necessary for targeted action.

BACKGROUND: In the Israeli-Palestinian conflict, water rights are one of the many disputed issues that await final status negotiations. As of yet, little progress has been made, and the quality and quantity of water in the West Bank and Gaza Strip (WBGS) remain dangerously poor and insufficient. Palestinians lack control over their water resources, meager as they are, which prevents their Ministry of Health from mounting an effective response to the water-related health crisis. Under international law, Israel's obligations consist of both those that are mandatory for an occupying power and those that are compulsory for a nation bordering a shared water source. Furthermore, shared waters must be allocated equitably, and individual states are prohibited from monopolizing collective resources. However, while Palestinian access to water is strictly limited, to the point that hospitals are occasionally forced to turn off life-saving dialysis machines, Israeli settlers enjoy uninterrupted supplies, abundant enough for swimming pools, sprinklers and flower gardens.

CONCLUSION: Before the current intifada, Palestinians in the WBGS frequently reported high rates of infection due to lack of sewage disposal and clean water. In recent months, Israeli sanctions have disrupted chlorination programs, causing several outbreaks of shigellosis. The international community can no longer accept these blatant violations of human rights. A precedent for enforcing international law as it pertains to water must be established. An international campaign, spearheaded by Israel's most ardent supporter, the United States, must demand that they comply with international law by providing quantities of water sufficient for meeting basic human needs. As the world's water supplies grow increasingly scarce, similar conflicts are bound to emerge elsewhere. In this respect, the Israeli-Palestinian water crisis is not unique. Consequently, international enforcement mechanisms are becoming vital, as this conflict may be indicative of future problems in all nations, especially if those in the developed world do not begin to view water as a nonrenewable resource that requires conservation.

SOCIAL ENVIRONMENT AND HEALTH: HEALTH AND HUMAN RIGHTS

Thirsty for Action: Public Health and Palestinian Water Rights

Jinna Samara Halperin

LEARNING OBJECTIVES: Participants attending this session will be able to learn and understand about the smoke-free Buddhist project and the monks' active involvement in strategies to reduce tobacco use consistent with their Buddhist beliefs. This will ultimately be an influencing factor in a general reduction of tobacco use in Cambodia generally.

BACKGROUND: As a Buddhist nation, Cambodia has a strong tradition of respect for Buddhist monks, who hold a great deal of influence in Khmer society. Tobacco use is not mentioned in Buddhist precepts; however, avoidance of harmful substances is one precept among others that could oppose tobacco use. Cambodia has very few restrictions on the supply or promotion of tobacco products and has smoking rates among the highest in the world for men (69 percent). Monks also smoke at alarming rates, and it is common practice for worshippers to offer cigarettes to monks. Monks have not known until recently about the harms of tobacco use. Monks are increasingly and collectively showing interest in going smoke free and acting as role models to have a powerful positive health influence in Khmer society. Adventist Development and Relief Agency/Cambodia has been working with Buddhist monks to: 1) establish smoke-free pagodas; 2) assist monks to quit; 3) train monks in cessation training methods; and 4) facilitate media campaigns with Buddhist leaders. Cooperation with the Ministry of Cult and Religion has been valuable.

CONCLUSION: The 'Khmer Quit Now' smoking cessation program has been used to help monks stop smoking, with an outstanding self-reported 87 percent quit rate after one year (n=1,069). The program's self-reported quit rates may be one of the highest in the world. This successful program warrants both biochemical validation and description of its effective methods. In smoking cessation, monks may find motivation from their religious beliefs, peer support and the incentive to establish smoke-free pagodas. The majority of monks who have participated in these programs have been young men, making this an intervention focused on both community leaders and youth. This presentation will focus on early research and experiences in the Tobacco or Health Program with the Buddhist community in Cambodia.

PARTNERS: National Center for Health Promotion, Ministry of Health and Ministry of Cult and Religion, Cambodia

ADDITIONAL AUTHORS: Ryan Sinclair, Greg Hallen

SOCIAL ENVIRONMENT AND HEALTH: HEALTH SYSTEMS

Buddhist Monks Going Smoke-Free in Cambodia

Yel Daravuth

SOCIAL ENVIRONMENT AND HEALTH: HEALTH SYSTEMS

Counterfeit and Substandard Drugs: A Global Problem, A Menace

Joyce Primo Carpenter

LEARNING OBJECTIVES: Participants will gain a better understanding about the problem of substandard and counterfeit drugs, recognize its impact on health and the economy, and appreciate the necessity of taking prompt measures to control its dissemination. Drug quality is a source of great concern in many developing countries. Recent reports indicate that the availability of substandard and counterfeit drugs has reached a disturbing proportion in these resource-poor settings. Use of poor-quality drugs has serious health implications, such as treatment failure, drug resistance, adverse effects, increased morbidity, mortality and wasted resources. Therefore, it is important to increase awareness of this problem among the health-care professionals, the general public and the policy-makers.

BACKGROUND: The United States Pharmacopeia (USP), through its drug quality and information program (DQI), conducted a literature search and reviewed studies and reports (journals, newspapers, research (including a recent USP drug quality study), internet reports, conference proceedings and newsletters) on substandard/counterfeit drugs, published between 1997 and 2002. The information collected were summarized in a matrix. USP, a not-for-profit NGO, has been the standard-setting authority for pharmaceuticals in the U.S. since 1820. These standards are used in 35 countries and are enforceable by the U.S. Food and Drug Administration. USP also produces chemical reference substances that are used in drug quality control testing.

CONCLUSION: The drug quality matrix included information on more than 30 countries (as producer, recipient or transit) from Africa, Asia and Near East, Europe and Eurasia, and Latin America and Caribbean regions. Among the pharmaceuticals sampled, analyzed, and reported as substandard or counterfeit were antimalarials, antituberculosis drugs, common analgesics and cough syrups, antibiotics and anthelminthics. The reported percentage of drugs that failed quality testing ranged from 6 to 60 percent; the estimated average of counterfeit drugs ran as high as 70 percent. Some health consequences also have been described because of use. This project provides more evidence of the widespread availability of substandard and counterfeit drugs and demonstrates their effect on public health. What is needed as a countermeasure is to step up efforts on quality assurance, monitoring drug potency, education and legal actions. The drug quality matrix will serve as a tool to increase awareness about the gravity of this problem. The matrix will be updated regularly and will be disseminated through the USP DQI website.

PARTNER: USAID

SOCIAL ENVIRONMENT AND HEALTH: HEALTH SYSTEMS

Evidenced-Based Approach to Improved Product Availability in Nigeria

Timothy R. Williams

LEARNING OBJECTIVES: Participants will be able to describe key findings from a logistics assessment in Nigeria and how findings will be used to improve the logistics system, name two instruments that can be used to assess logistics systems and understand how each should be applied, and appreciate the particular challenges of improving reproductive health (RH) logistics in the case of Nigeria.

BACKGROUND: Effective logistics systems ensure that clients at health facilities are consistently able to obtain the quality products they need. To achieve this, organizations must select appropriate products, forecast the amount needed, procure the right amount, and deliver products effectively to storage and service facilities. When a country can carry out all of these activities well with diminishing external assistance, they can be said to achieve commodity security. The Nigerian Federal Ministry of Health (FMOH) is attempting to revitalize their contraceptive logistics system to improve product availability to clients and move toward RH commodity security. Nigeria faces a number of unique challenges, including its sheer size as the largest country in Africa, substantial decentralization of the health system and years of insufficient resources during the recent period of military rule.

METHODOLOGY AND RESULTS: A facility-based survey was carried out in 123 public sector and 142 private sector facilities covering a range of socioeconomic and demographic characteristics. Key indicators measured included availability of a range of products on the day of the visit and in the previous six months, quality of record keeping, time needed to fill orders and storage conditions. Results showed that the logistics system is well designed in theory, but its implementation is not consistent with the design. Only 24 percent of service delivery sites kept stock records, and none were accurate for all products. Only 22 percent sent forms in on time, making it difficult to deliver appropriate amounts of supplies. Transport and communication is lacking at most levels. As a result, product availability to clients is poor.

CONCLUSION: Over the past several years, the RH logistics system in Nigeria has deteriorated to the point where many sites assume that chronic product shortages will continue indefinitely. Following the assessment, a system design workshop was held to develop a strategy for improving the system. Among the many recommendations suggested, the following are noteworthy: 1) build on existing strengths; 2) focus on areas with greatest unmet need; 3) work with the private sector to improve market segmentation; 4) develop a sound pricing policy for products sold through the public sector; 5) disseminate guidelines on record keeping and reporting, and ensure that forms are available for all sites to use; 6) develop a cost-effective transport strategy; and 7) mobilize resources to sustain the suggested interventions.

PARTNERS: FMOH, Nigeria, USAID, VISION Project

ADDITIONAL AUTHORS: M.S. Ameshi, Foyin Oyebola, Lea Teclemariam

POSTERS

Improving Access to Maternity Services of Women in Remote Rural Areas in the Province of Tetouan

Nezha Mokit

LEARNING OBJECTIVES: Participants will be able to indicate the factors of change that can improve the access to health services in remote rural areas.

BACKGROUND: The Ministry of Health (MOH) team of the Moroccan province of Tetouan implemented a special strategy to reach out to women in Benkarrich, a remote rural area. Twenty-five sentinel women were selected and trained to strengthen the mobile service delivery strategy. The role of sentinels was to primarily facilitate the recruitment of women through community IEC (information, education, communication) meeting on safe motherhood.

METHODOLOGY AND RESULTS: The sentinel strategy was introduced to complement the existing mobile strategy as a means to better respond to the needs of population living in difficult geographical environments. The sentinel women were selected through a participatory process on the basis of consent and educational achievements. The women were trained by the local health team on interpersonal communications and safe motherhood. The implementation of the strategy required a complex process of gathering all actors: population, service providers and local authorities. In addition, the provincial technical working group on quality provided technical assistance to train the community health center staff in quality assurance techniques. One year after implementation, the initial results are encouraging. The level of knowledge on risks during pregnancy and delivery among women increased from 16 percent to 56 percent. The average number of prenatal visits increased from one to two visits per woman. In 2000, the number of deliveries in the community health center was six. In 2001, the number of deliveries increased to 45. Four women with obstetrics complications were evacuated on time and in good transport condition to the provincial hospital.

CONCLUSION: An innovative service delivery strategy based on sentinel women was introduced in a remote rural community of the Tetouan province area in Morocco to better respond to the needs of population. The strategy demonstrated significant improvement in access and use of maternal services by the women of this rural community. The success of this project was also possible because of the participation of several actors, including local NGOs and the local government.

PARTNERS: USAID, AECI, local NGOs, John Snow, Inc.

ADDITIONAL AUTHORS: Mustapha El Mahoti, Rachid Bekkali

Japan-United States Partnership for HIV/AIDS Control and Maternal and Child Health in Nepal

Hiroko Yamamoto

LEARNING OBJECTIVES: Participants will be able to understand the Japan-United States partnership for global health and its implementing process in Nepal.

BACKGROUND: Japan and the U.S. have been working closely together for global health and harmonizing policies in the sector for more than a decade. After the evaluation of a seven-year collaborative action under the 'Common Agenda,' both countries agreed upon and signed the 'Japan-USAID Partnership for Global Health' between the Japanese Ministry of Foreign Affairs and USAID. To scale up collaborative action after the renewed partnership, a joint project formulation mission was sent to Nepal.

CONCLUSION: After the joint work of situation analysis and strategic planning on health sector of Nepal in July 2002, Japan and USAID signed a new cooperation framework for maternal and child health and HIV/AIDS control in Nepal. 1) Maternal and child health: Japan and the U.S. will collaborate and coordinate their programs/projects on community-based Integrated Management of Childhood Illnesses, school health, polio eradication, Expanded Program on Immunization, nutrition and safe motherhood. 2) HIV/AIDS: Japan and the U.S. will support behavior change interventions to high-risk adults and youth, expanding voluntary counseling and testing, and strengthening laboratory capacity.

PARTNERS: Japan International Cooperation Agency, USAID

ADDITIONAL AUTHOR: Osamu Kunii

SOCIAL ENVIRONMENT AND HEALTH: HEALTH SYSTEMS

Pediatric Oncology International Outreach Builds General Medical Infrastructure

Judith A. Wilimas

LEARNING OBJECTIVES: Participants will be able to understand how improvements in subspecialty areas can enhance overall health care in resource-poor locations.

BACKGROUND: Treatment of childhood cancer requires a basic health-care infrastructure and adequate funding. The St. Jude Children's Research Hospital International Outreach Program develops pediatric oncology programs by: 1) establishing partnerships with local medical institutions and fund-raising organizations; 2) facilitating interaction with other organizations; 3) supporting local programs and training personnel; 4) developing regional programs; and 5) using technology optimally. The primary goal is local and regional self-sufficiency. Clinical partnerships in 16 cities (13 countries) were established. Representative site-specific priorities are nurse training, infection control, diagnostic capabilities, site-specific treatment plans and continuing education. Physicians in infectious diseases, radiology, intensive care and ophthalmology also receive training.

CONCLUSION: In addition to improving the survival of children with cancer, this model has brought about significant progress in the standard of clinical practice, the confidence of clinicians and community involvement. To develop necessary regional infrastructure, we have collaborated with the Association of Central American Pediatric Hematologists/Oncologists, established a Central American immunophenotyping resource, developed the International School of Pediatric Oncology Nursing in El Salvador, established telemedicine, telepathology and telesurgery programs in Brazil, and made lectures available through the Cure4Kids Web site. Approximately $4.6 million was raised in partner communities in 2001 for program support, and more than 100 oncology nurses were trained. Infection control programs established to support pediatric oncology services have improved overall infection control. The infection control program established in Morocco serves the overall needs of three large hospitals. Improvement has been observed in the skills and confidence of program participants, as well as a ripple effect on local health care. For example, a government-sponsored training program for obstetrics/gynecology nurses was patterned on our pediatric oncology nurse-training program. Education programs have been developed for other health-care workers. Training of infectious diseases physicians has facilitated development of HIV programs. Thus, development of subspecialty programs in resource-poor locations can have a far-reaching impact on overall health care by improving the local and regional health care infrastructure.

PARTNERS: St. Jude and partner site staff and foundations, Milan International School of Pediatric Hematology/Oncology, National Children's Cancer Society, Society of Professional Nurses

ADDITIONAL AUTHORS: Raul Ribeiro, Lynne Bowers

SOCIAL ENVIRONMENT AND HEALTH: HEALTH SYSTEMS

PROFAMILIA's Role in Health Sector Reform in Colombia

Gabriel Ojeda

LEARNING OBJECTIVES: Participants will be able to identify what organizational changes are required to compete successfully in a health sector reform environment.

BACKGROUND: The case study of PROFAMILIA/Colombia demonstrates that an NGO can successfully sustain its sexual and reproductive health programs in a health sector environment and continue to serve the poorest population.

METHODOLOGY AND RESULTS: Three instruments were used to compile the information needed for the case study: semi-structured interviews, a diagnostic and participatory strategic design workshop, and a review of documents. To study PROFAMILIA's client profile, a sample of 7,800 clients were surveyed in 25 clinics. Both men and women were interviewed. The survey was not conducted in youth centers and programs. The sample was proportional to the total of family planning and diversification.

CONCLUSION: PROFAMILIA was able to compete successfully in a health sector reform in Colombia by creating a group to study Law 100, by training its staff, by reorganizing its administrative and managerial structure, by investing in the infrastructure of its clinics, by studying its market, and by analyzing and reducing the costs of its services and products. Based on the results of the client profile survey, not only have the living conditions of PROFAMILIA's users worsened between 1995 and 2002 but they are also below the national average as reflected in the ENDS of 2000.

PARTNERS: Catalyst Consortium, PROFAMILIA, Abt Associates

ADDITIONAL AUTHORS: Ivan Jaramillo Perez, German Lopez, Maria Isabel Plata, Marie-France Semmelbeck, Orlando Hernandez

Redesign of Service Delivery Strategy Based on Analysis of Quality Indicators

El Hanefi Habiba

LEARNING OBJECTIVES: Participants will be able to see that population health needs are better met through service delivery strategies tailored to population needs. Such needs are determined through a study of quality of service indicators.

BACKGROUND: Tanger-Tetouan (TT) is one of the Moroccan regions where family planning (FP) performances have been poor for the last five years. Despite the implementation of generic strategies centered on training and promotion campaigns, the use of services did not increase substantially. Two years ago, the TT health team decided to redesign its service delivery strategy using an innovative approach. It identified three factors to analyze the situation: 1) the quality of FP services; 2) the quality and impact of previous practitioners training sessions as well as their need for refresher courses; and 3) the quality of the service delivery environment.

METHODOLOGY AND RESULTS: A study was designed by the regional team with technical assistance from the central level to better understand the low performance of the program using the three factors. The study concerned the five provinces of TT region. Access to the target population used the random sampling method. The targeted population included clients, practitioners and management teams of public health clinics. Data collection tools used during the study were direct observation of health practitioners, client interviews and inventory of FP medical equipment available in the clinics. A training session was organized for the interviewers and investigator in FP techniques, observation techniques and the use of EPI Info/Statistical Package for Social Sciences software.

CONCLUSION: The results of the study were used by local health teams in different clinics to put together a plan to stimulate the demand and use of FP services.

PARTNERS: USAID, John Snow, Inc.

ADDITIONAL AUTHORS: Assia El Abbassi, Sati Sayah

Social Marketing Project in Low-Income Communities of Rio de Janeiro, Brazil: A Demand-Supply Driven Approach for Condom Use and Gender Equitable Relationships

Miguel Barbosa Fontes

LEARNING OBJECTIVES: Participants will learn successful social marketing (SM) strategies for sexual behavior change in young men for fighting AIDS among youth.

BACKGROUND: There is a consensus of the need to incorporate young men in HIV/AIDS prevention and reduction of gender-related violence and that their behavior may put themselves and partners at risk. SM strategies for sexual behavior change associated with the promotion of condoms, negotiations of condom use and equitable gender relationships are powerful tools for fighting AIDS among youth. However, those strategies must be demand-driven and have to count with a real participation and involvement of the target population in all steps of the strategic planning of the process. Current condom SM projects are developed based only on supply-side strategies (price subsidy and retail sales), lacking involvement of youth and resulting in limited impact for continuous condom use. John Snow Brasil/PROMUNDO developed an SM strategy for promotion of sexual behavior change, gender equitable relationships and use of condoms among youth in low-income communities of Rio de Janeiro. The strategy has been designed in partnership with condom manufacturer SSL International. Sixteen young men were trained as promoters to engage peers on issues of gender-related violence and sexual health. They were main authors of the development and implementation of a demand-driven SM mix strategy, assessment of local market conditions and integration of a condom accessibility approach with an ongoing peer education project. A condom SM strategy was launched with local NGOs and community-based associations to train young men to act as peer-to-peer promoters for healthy and gender equitable sexual behavior. In order to guarantee accessibility of condoms, they were also trained in selling strategies of condoms at youth places. Therefore, this strategy is an income-generating and a behavior change intervention. Demand-driven SM mix strategy includes: 1) place: condoms are available at alternative youth gathering places (e.g., funk parties and local bars, schools, squares); 2) promotion: condoms are sold with a magazine produced with the input from the youth and design of messages for the reduction of perceived social cost of using and negotiating use of condoms; 3) social product: young men's involvement in gender equitable relationships and use of condoms dissemination among peers; 4) price" setting the 'right price' based on youth's willingness to pay (US$0.33 for pack of three).

CONCLUSION: Condom SM must be demand-driven and count on its real involvement of target population. When field-testing the SM mix, youth provided useful insights. Data were incorporated into all phases of the condom SM strategy. It is an alternative process to current supply-driven projects for condom SM, although accessibility (place) in our strategy is also considered a main issue.

PARTNERS: Instituto Promundo, SSL International

ADDITIONAL AUTHORS: Cecilia Studart, Gary Barker, Bebhinn NiDhonaill, Peter Roach

POSTERS

Substandard and Counterfeit Drugs: A Global Problem, A Menace

Joyce Primo Carpenter

LEARNING OBJECTIVES: Participants will gain a better understanding about the problem of substandard and counterfeit drugs, recognize its impact on health and the economy, and appreciate the necessity of taking prompt measures to control its dissemination. Drug quality is a source of great concern in many developing countries. Recent reports indicate that the availability of substandard and counterfeit drugs has reached a disturbing proportion in these resource-poor settings. Use of poor-quality drugs has serious health implications, such as treatment failure, drug resistance, adverse effects, increased morbidity, mortality and wasted resources. Therefore, it is important to increase awareness of this problem among the health-care professionals, the general public and the policy-makers.

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PARTNER: USAID

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Photo by Keith Mumma

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PHYSICAL ENVIRONMENT AND HEALTH: INDUSTRIALIZATION AND DEVELOPMENT

Community Mobilization in Addressing Environmental Hazards

HEALTH CARE WITHOUT HARM: FOCUS ON MEDICAL WASTE INCINERATION

Charlotte Brody

LEARNING OBJECTIVES: Participants will be able to identify the role that community mobilization can play in changing health care waste disposal practices. Participants will also be able to describe effective alternatives to medical waste incineration.

BACKGROUND: Incineration does not make medical waste disappear. The gas by-products and resulting toxic ash endanger the health of all of us, particularly the members of low-income communities where these incinerators are generally located. Many of these communities are organizing to address the threat to their health. This mobilization can provide a strong support for health-care policy and health-care administrators to make positive changes in medical waste practices that benefit the community and the institution. Incinerators release a variety of pollutants into the air, including dioxin, a known carcinogen that has been linked to birth defects, immune system disorders and other harmful health effects. For years, health experts and community groups have opposed medical waste incineration because of concerns about dangerous emissions, but they lacked concrete data about what choices might be better for human health and the environment. Now a wealth of information is available to help health-care staff work with their communities to choose medical waste treatment methods that can protect people, the planet and the bottom line.

CONCLUSION: When medical professionals and community health and environmental groups join forces, they can create important change in medical waste practices. Moving from the harmful health effects of medical waste incineration to alternative waste disposal practices is essential to addressing environmental health effects of the health-care system.

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PHYSICAL ENVIRONMENT AND HEALTH: INDUSTRIALIZATION AND DEVELOPMENT

Community Mobilization in Addressing Environmental Hazards

UNTANGLING LINKS BETWEEN PUBLIC HEALTH AND THE ENVIRONMENT

Devra Lee Davis

LEARNING OBJECTIVES: Participants will be able to recognize chronic environmental health hazards and evaluate the limits of the health-care system in addressing them. Participants will recognize the roll of grassroots groups in addressing environmental health hazards.

BACKGROUND: Despite a number of major improvements in global health conditions, such as broader access to sanitation, avoidable factors not addressed by the health-care system remain major determinants of death and disease. Public health reflects complex interplays between socioeconomic systems and the health sector. The health-care system treats disease, but is not organized to prevent many underlying causes. Major sectors affecting health include agriculture, transportation, industry, energy, water and waste, housing, education, industry and the military. Grassroots groups outside the current health-care system are addressing environmental health hazards in local communities and can be expected to grow as a constructive force for health.

METHODOLOGY AND RESULTS: Evidence that environmental agents affect human health can be in experimental and epidemiologic studies that are reviewed and indicate effects of toxins across a range of chronic disorders. Nevertheless, the difficulty of conducting environmental health assessments hampers scientific answers, particularly given evidence of windows of vulnerability and the fact that many agents leave no residues. Progress in addressing chronic diseases is limited by attention to individual level factors and limitations of the medical model.

CONCLUSION: By returning our attention to broad-scale factors such as those affecting the quality of air, water, workplace, household environments and the global climate, and by utilizing the precautionary principle and the principles of sustainable development, we may better achieve reductions in chronic diseases.

PARTNERS: Local Motion, Grosse-Pointe, Michigan, the Household Toxin Institute, Seventh Generation, the Mid-Hudson Options Project, Long Island Breast Cancer Coalition, Breast Cancer Fund, Breast Cancer Action, Women's Community Cancer Project, Children's Health and Environment Coalition, other breast cancer and child health groups

ADDITIONAL AUTHOR: Pamela S. Webster

LEARNING OBJECTIVES: Participants will learn about the characteristics of the environmental health problems in the south of the former Soviet Union, specifically Central Asia and the Caucasus, and how to develop a framework to conduct comparative studies for evaluating the effectiveness of the integration of information technology with environmental health interventions.

BACKGROUND: Overflow of the Caspian Sea has caused an environmental disaster on the coastal zones. Drying of the Aral Sea has exacerbated environmental problems in Central Asia. The countries on both eastern and western sides of the Caspian Sea are experiencing transition in their health-care systems. Having considered a high prevalence rate of certain diseases in these countries, health care will remain a top priority for local governments. The Caspian Sea Region is rapidly becoming a center of focus for multinational firms and international development organizations. To date, no major health-care project has been implemented by North American organizations in Central Asia and the Caucasus. During recent months, significant efforts have been made to implement development programs in the south of Central Asia. On the west side of the Caspian Sea, a non-homogenous social structure necessitates a more customized approach for offering health-care technologies to the Ministries of Health, which, like their counterparts in the Newly Independent States (NIS), are still the only planners and evaluators of health-care programs. However, increasing presence of Western petroleum companies, regardless of a fear for more environmental pollution, has raised hopes for introducing feasible technologies for the purpose of the establishment of a regional environmental health network. An integrated health information technology is an essential tool to make sure that health-care programs at clinical and social levels will be sustainable. A telehealth platform can serve as a hub for the neighboring countries. Lack of suitable transportation routes in several urban and rural areas throughout Central Asia is a factor that makes potential application of telehealth more important to local authorities.

CONCLUSION: A Caspian telehealth network may include components such as teleconsultation, tele-education, a public health information network, an environmental health surveillance system, an offshore medical support system, an electronic medical record system for program evaluation and research purposes, a travel medicine information system and a technical support system of community awareness programs. In the Caucasus as compared with Central Asia, the private sector has been able to more quickly penetrate the information technology market. In these countries, educational institutions such as newly established private universities, which have mainly adopted North American curricula, could efficiently contribute to human resources for a regional telehealth network.

PARTNERS: Caspian-Central Asia Foundation, Khazar University, Avicenna International Foundation, Central Asian Medical Journal

ADDITIONAL AUTHORS: Nodira A. Abdujamilova, Masoomeh Raghibdoust, Abedin Enayati

PHYSICAL ENVIRONMENT AND HEALTH: INDUSTRIALIZATION AND DEVELOPMENT

Impact of Industrial and Agro-Chemical Pollution

A FRAMEWORK FOR ENVIRONMENTAL HEALTH INTERVENTION IN CENTRAL ASIA AND THE CASPIAN SEA REGION

Ali Artaman

LEARNING OBJECTIVES: Participants will learn about problems of pesticide-related illnesses among agricultural workers in California. Information will include problems of under-reporting, weak worker safety laws and their poor enforcement, and the efforts of a statewide pesticide reform coalition to advocate for improved worker safety laws and better enforcement.

BACKGROUND: Analyses of state-collected data on pesticide-related illnesses and information on enforcement of worker safety laws describe a persistent crisis among agricultural workers in California and around the world.

METHODOLOGY AND RESULTS: Pesticide Action Network North America, United Farm Workers of America, AFL-CIO and California Rural Legal Assistance Foundation analyzed California agricultural poisoning data and enforcement information compiled by government agencies. Nearly 500 pesticide poisonings were reported for California farm workers every year from 1997 to 2000. The actual number of pesticide-related illnesses are unknown, as many poisonings go unreported. The greatest numbers of reported poisonings occurred as a result of soil fumigation and pesticide applications to grapes, oranges and cotton. Fifty-one percent of the cases were due to exposure to pesticide drift and another 25 percent resulted from exposure to pesticide residues on the fields in which farm workers labor. Violations of worker safety laws are common and contributed to 41 percent of reported poisonings. In fiscal year 2000/2001, fines for confirmed violations were issued less than 20 percent of the time and the majority of fines were for less than $400, a negligible deterrent for employers and professional pesticide applicators. An additional 38 percent of reported poisonings occurred while apparently following worker safety laws, indicating that existing laws are inadequate to protect workers from pesticide exposure.

CONCLUSION: The information presented here was recently released in the report 'Fields of Poison 2002: California Farm Workers and Pesticides' produced by a 160-member statewide coalition, Californians for Pesticide Reform (CPR) and presented at eight press conferences around the state. CPR works to raise public awareness about the persistent crisis of pesticide exposure among farm worker communities and other communities throughout the state. Coalition activities have successfully pressured regulatory agencies and legislators to recognize the need to improve worker safety laws and their enforcement.

PARTNERS: United Farm Workers of America, AFL-CIO, California Rural Legal Assistance Foundation

ADDITIONAL AUTHORS: Anne Katten, Martha Guzman, Kristin Schafer

PHYSICAL ENVIRONMENT AND HEALTH: INDUSTRIALIZATION AND DEVELOPMENT

Impact of Industrial and Agro-Chemical Pollution

GREATER RISKS, FEWER RIGHTS: CALIFORNIA FARM WORKERS AND PESTICIDES

Margaret Reeves

PHYSICAL ENVIRONMENT AND HEALTH: INDUSTRIALIZATION AND DEVELOPMENT

Multidisciplinary Approaches to Environmental Health

ECOSYSTEM HEALTH APPROACHES TO HUMAN HEALTH: CHANGING THE FOCUS OF HEALTH CARE

Victoria E.H. Lee

LEARNING OBJECTIVES: Participants will be able to define the main concepts in ecosystem health, describe the advantages and disadvantages of ecosystem health approaches to human health, realize the relevance of the ecosystem health approaches in improving health and well-being, and recognize strategies of implementation for ecosystem health approaches to human health in various disciplines.

BACKGROUND: As we enter the 21st century, human health is becoming ever more dependent on achieving sustainable life-support systems and restoring health of the Earth's ecosystems. However, the linkages between ecosystem health and human health have not been realized in the practices of health professionals. Ecosystem health approaches to human health provide an essential link as a prevention model to bridge the gap between the health of natural ecosystems and the health of humans. Ecosystem health is transdisciplinary by nature, where the key determinants of health include the intricate relationships in human-dominated ecosystems, which include cultural, social, political, environmental and economic systems. Ecosystem health approaches to health then equate to a broader perspective, investigating not only the pathophysiological aspects of disease but also keeping in mind the dynamics of the ecosystems that might make a particular person, community, country or globe more susceptible to disease. The ecosystem health model of health was investigated through case studies, with a special focus on public and professional education.

CONCLUSION: It is only with a transition to a more holistic approach to health that we can begin to address the fact that the determinants of individual and population health will be found increasingly in ecosystem health. Ecosystem health approaches to human health provide meaningful and valid enhancement in human health by facilitating education and training of health professionals to tackle problems 'upstream' before they result in disease, and to develop ways of improving collaboration across disciplines.

PARTNERS: University of Western Ontario Ecosystem Health Implementation Team, International Society for Ecosystem Health, International Development Research Centre, International Federation for Medical Students' Associations

ADDITIONAL AUTHORS: David Rapport, John Howard, Robert Lannigan

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PHYSICAL ENVIRONMENT AND HEALTH: INDUSTRIALIZATION AND DEVELOPMENT

Multidisciplinary Approaches to Environmental Health

THE ROLE OF GEOSCIENCES IN PROTECTING GLOBAL HEALTH

Joseph E. Bunnell

LEARNING OBJECTIVES: Participants will be able to identify certain complex global public health problems with environmental causes or components that can be best approached in a multidisciplinary manner, with the participation of geoscientists, as evidenced by a number of selected case studies.

BACKGROUND: Western health research has long been characterized by a reductionist approach. Many advances were made, but many opportunities were lost. A growing number of scientists are shifting to systems approaches, and understand that many diseases result from complex and dynamic interactions of environmental and host factors. For instance, new technologies enable us to include more potential etiological variables than in the past, and in some cases we are finding that previously overlooked parameters are critical. The role of the geosciences in helping understand such multidimensional disease systems has been underappreciated. Several examples will be presented of how geoscientists, working in partnership with biomedical and public health researchers, have come to better understand certain environmental health issues, and are helping achieve solutions to major public health problems.

METHODOLOGY AND RESULTS: Several case studies were selected for presentation. Analytical methods include geographic information systems (GIS) and remote sensing, spatial statistical modeling, molecular microbiological and immunological assays, gas chromatography/mass spectrometry, inductively coupled plasma mass spectrometry, neutron activation, electron microscopy and total ion chromatography.

CONCLUSION: The case studies have demonstrated that the state of knowledge for certain disease systems has been advanced as a result of the involvement of geoscientists in transdisciplinary teams. Arsenosis and fluorosis in China: It was found that ingestion of foodstuffs dried over As- and Fl-enriched coal burned in unvented stoves provides a novel mechanism of exposure. A field test kit was developed to provide an intervention that may be successfully implemented in this developing country. Balkan endemic nephropathy, a severe, ultimately fatal kidney disease: Naturally occurring low-rank coal beds are the principal aquifers supplying water to rural villagers. The water leaches toxins such as aromatic amines from the coal, possibly contributing to the nephropathy. Global transport of dust: Remote sensing devices on satellites and airplanes monitor huge transoceanic dust clouds. Such clouds carrying heavy metals, particulate matter and pathogenic microbes are killing Caribbean coral, and may induce asthma and allergies in exposed human populations. Geoscience techniques have revealed connections between earthquakes and outbreaks of the respiratory disease Valley Fever. Collaboration between the geoscience and biomedical/public health communities offers promise for developing innovative solutions to minimize or prevent a wide range of global health problems.

ADDITIONAL AUTHOR: Robert B. Finkelman

LEARNING OBJECTIVES: Participants will be able to understand the challenges of integrating a health agenda into a trade and economic forum.

BACKGROUND: The Asia Pacific Economic Cooperation (APEC) was established in 1989 in response to the growing interdependence of economies around the Pacific Rim. Its 21 member economies accounted for 47 percent of global trade in 2000. APEC has evolved from an informal dialogue group to a key vehicle to promote regional trade and economic cooperation. APEC convenes annual meetings of its foreign ministers and leaders, and periodic meetings of ministerial sectors. APEC's organizational structure does not formally include health. As interest grew to address the problem of emerging infectious diseases (EID) globally, the United States introduced this as a potential APEC priority at the Science and Technology Ministerial Meeting in 1995. Since 1995, the U.S. has provided leadership to APEC's evolving infectious disease agenda, which has included 15 specific projects, an EID action plan (1997) and a more recent APEC Infectious Disease Strategy (2001). The strategy describes the rationale for addressing infectious diseases within the context of trade and economics, i.e., APEC, and outlines six main areas for action: electronic networking, surveillance, outbreak response, capacity-building, partnering across sectors, and economic and political leadership. Most of APEC's health efforts have been housed within its Industrial Science and Technology Working Group (ISTWG). Among the most problematic challenges to date have been: 1) engagement by the health sectors of APEC economies; 2) active participation of more than a small handful of economies; 3) strategic versus opportunistic project development; and 4) effective understanding and partnering across sectors, including penetration of leaders' messages into necessary sectors within economies. APEC leaders first addressed health in 2000, calling for development of the strategy. In 2001, they endorsed the strategy and called for its implementation. In 2002, they expanded the health agenda beyond infectious diseases and elevated its importance within APEC.

CONCLUSION: Health is important to trade and economics. It has been challenging to incorporate a health agenda into APEC, perhaps due to a lack of understanding of the value of health to other sectors. The understanding and commitment of individuals in the U.S. and a few other economies has been critical to keep the APEC health agenda alive. Elevation of health as a priority of APEC's political leaders has enhanced its visibility in ways relevant directly to APEC and indirectly to other political fora.

PARTNERS: Health, science and technology and other sectors in APEC economies; government, academia, industry

PHYSICAL ENVIRONMENT AND HEALTH: INDUSTRIALIZATION AND DEVELOPMENT

Trade-Related Infectious Diseases

THE ASIA PACIFIC ECONOMIC COOPERATION'S INFECTIOUS DISEASE AGENDA, 1995 TO PRESENT

Melinda Moore

LEARNING OBJECTIVES: Participants will be able to recognize trade-related infectious diseases.

BACKGROUND: The hastened emergence of human infections is linked to the boom of global trade in goods. Business planning for global markets has not routinely included the cost of assuring public health safety in innovation in products, production, handling and transportation. At the same time, the infrastructure for assuring safety is incomplete, especially in poorer economies.

METHODOLOGY AND RESULTS: Case studies from the literature were reviewed as well as pertinent international agreements in the GATT and International Health Regulations regimes. A qualitative analysis of urgent notifications received by the SPS secretariat since 1996 was carried out and the global alert data of WHO for 2000-2002 were reviewed. Using these two sources as reference data for time and events, data on the trade flow from the COMTRADE UN dataset were linked to events through product code. A time series analysis was done to describe examples of human epidemics disrupting global trade. Human epidemics are linked to global trade through amplification of transmission in product, and in the impact they in turn have on trade flows. Trade flow data can be used to characterize the temporal relationship between events and trade disruption.

CONCLUSION: Trade-related infections will become increasingly important. As the International Health Regulations are revised, insight into the nature of these events and their costs will become central to policy choices. National and global agencies involved in trade and health need to synergize to assure successful epidemic control in the face of accelerated global commerce.

PHYSICAL ENVIRONMENT AND HEALTH: INDUSTRIALIZATION AND DEVELOPMENT

Trade-Related Infectious Diseases

EMERGENT INFECTIONS: THE 'MACRO' AND 'MICRO' OF GLOBAL TRADE

Ann Marie Kimball

ROUNDTABLES

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PHYSICAL ENVIRONMENT AND HEALTH: INDUSTRIALIZATION AND DEVELOPMENT

Unique Ways to Protect Forests

EFFICIENT ENERGY USE REDUCES DEFORESTATION IN KARAGO CAMP

Sosthenes Elieza

LEARNING OBJECTIVE: By the end of this session, participants will recognize the importance of efficient energy use promotion in forest protection.

BACKGROUND: Following the Burundian influx in 1999 to the western part of Tanzania, a new camp (Karago camp) was established to accommodate about 50,000 refugees. Six months later, UMATI was requested to do environmental protection as part of a community services program. In that camp set up, fuel wood is the only source of energy for cooking.

METHODOLOGY AND RESULTS: A review of the program identified the main cause of deforestation to be fire wood collection, which is a continuous phenomenon. Before intervention on household energy consumption, a survey was conducted. Results revealed that firewood consumption/person/day was 3.43 kg. Given the camp population of 50,000 people, that would mean 62,769 metric tons of firewood/year. Given an average of 100 kg/tree, 627,690 trees are used as firewood per year. Also it was learned that no family practiced an energy-saving method or technology. An intervention was community based. It started by identifying and formulating an environment committee from the community, with 50 members. All committee members were trained on various energy-saving practices and technologies. Also those committee members were made aware of direct benefits of keeping environment protection gained by individuals practicing energy efficiency methods and technologies. Committee members played a key role in awareness creation while extension workers maintained supportive field visits. Women and school children were targeted. Practice evaluation meetings were regularly organized. A survey after one year revealed that out of eight cooking practices and technologies, at least 86 percent of the community members practiced five. Per capita energy consumption decreased to 2.1 kg firewood/person/day, a reduction of 24,739 metric tons/year. Given an average of 100 kg/tree, 247,390 trees were saved per year, and the camp remained green, vegetated and shaded.

CONCLUSION: Deforestation and degradation of forests are the main environment problems associated with the refugee situation and have various impacts on general health and habitat. The main factor influencing the type and scale of impact is the refugee energy consumption pattern in terms of quantity and refugee number. Promotion of efficient energy use, if carried out in a timely and thorough community-based approach, is a cheap yet cost-effective way of reducing deforestation by decreasing the demand on forest product for fuel wood.

PHYSICAL ENVIRONMENT AND HEALTH: INDUSTRIALIZATION AND DEVELOPMENT

Unique Ways to Protect Forests

RURAL RADIO IN MADAGASCAR: REINFORCING HEALTH-ENVIRONMENT PROGRAMS

Jennifer Talbot

LEARNING OBJECTIVES: Participants attending this session will understand the role that rural radio plays in reinforcing community-based health-environment programs.

BACKGROUND: The rural radio Akon'Ambanivolo located near a forest corridor in the eastern part of Madagascar plays an important role in broadcasting messages that reinforce health and environment field activities in rural villages. In order to protect some of the last remaining highly biodiverse forests in Madagascar and to assure that the surrounding populations are in good health, two rural development partners, LDI and SAF/FJKM, work with the Voahary Salama Association to implement integrated health-environment field activities, which include maternal, child and reproductive health programs, agricultural intensification extension and community-based forest management plans. LDI and SAF work closely with the farmer-owned and run Radio Akon'Ambanivolo and trained local community members to produce and broadcast separate health, agriculture and environment messages as well as integrated health-environment shows. These messages and shows are designed to complement and support field programs. Rural radio is one element of the overall information, education, communication (IEC) strategy of the Voahary Salama Association. Other IEC strategies implemented by Voahary Salama partners to promote behavior change that leads to healthier forests and healthier communities include technical brochures, child-to-community, farmer-to-farmer, and a champion community program.

CONCLUSION: Rural radio plays an important role in the IEC strategy of Voahary Salama and its rural partners by reinforcing community-based activities through the diffusion of health, environment and integrated health-environment messages and shows. This rural radio program is effective for three main reasons. First, the technical content of the radio messages and shows is complementary to and supports the ongoing field activities. Second, the integrated health-environment shows are produced by the local community health-environment volunteers, who are well trained and respected in their communities. And third, the broadcasts are widely listened to because the radio is farmer-owned and a source of pride for the region.

PARTNERS: Radio Akon'Ambanivolo, FITARA, Federation Kolo Harena Tongalaza, CDIA, LDI, SAF/FJKM, Packard and Summit Foundations, USAID, EHP/ECHO, Voahary Salama Association

PHYSICAL ENVIRONMENT AND HEALTH: UNDERDEVELOPMENT

Community-Based Water Management

DAMS AND DISPLACEMENT IN BRAZIL: LOCAL PARTICIPATION IN ENVIRONMENTAL DECISION-MAKING

Sabrina McCormick

LEARNING OBJECTIVES: Participants will be able to better understand the history and impacts of dam building in Brazil, as well as the social contestation that has been focused on making energy policy more participatory. They will also learn about strategies that have resulted in improved outcomes of dam building.

BACKGROUND: Over 90 percent of Brazil's energy is generated by hydroelectricity in the form of large dams. Despite their importance in supporting development, negative outcomes have been identified. Therefore, dams have become a controversial issue, particularly in the past 20 years. This controversy has stimulated the formation of a World Bank commission to examine their social, health and environmental effects. The World Commission on Dams examined one large dam in Brazil, Tucurui. This report concluded that the development of dams can carry with it negative unintended consequences, particularly in the areas of health and the environment. In the case of Brazil, this included increases in AIDS, malaria, infant mortality, poverty and malnutrition. My research investigated the results of large dam building, the social contestation of dams aimed to prevent these outcomes, and the processes through which energy policy is altered by this contestation. The movement of dam-affected people in Brazil has worked to prevent such outcomes by changing the way that energy policy decision-making takes place, particularly by working with researchers who construct knowledge about environmental and health outcomes of potential projects. It has been the primary force behind resettlement planning and amelioration of the effects of dams. Therefore, it has played a significant role in improving development through democratizing decision-making. This has led to improved outcomes in environmental health.

METHODOLOGY AND RESULTS: My analysis of these questions is based on qualitative interviews and observations collected throughout several regions in Brazil in 2002. It includes 30 interviews of dam-affected people, researchers who work with these local populations, and government officials who construct dam policy, as well as ethnographic observations of displaced communities, resettled communities, meetings between researchers and activists, and social movement activities. The sample of interviewees was a purposive grouping, followed by a snowball sample.

CONCLUSION: The analysis shows that anti-dam activists have played an influential role in alerting the planning of dams, and even occasionally preventing their construction. This participation has resulted in improved standards of living for the organized local populations. To prevent further dislocation and to improve environmental health effects of Brazilian energy policy, lay people, such as social movement activists, should be involved in research regarding the effects of large dams.

PHYSICAL ENVIRONMENT AND HEALTH: UNDERDEVELOPMENT

Community-Based Water Management

HEALTH IMPACTS OF A COMMUNITY-BASED WATER MANAGEMENT PROGRAM

Ashley Aakesson

LEARNING OBJECTIVES: Participants attending this session will be able to describe impacts of a community-based water development program on maternal and child health in Southern Ethiopia. They will be able to assess the applicability of this approach to similar contexts in other locations.

BACKGROUND: For several years, Save the Children Federation, Inc. (SC) has been implementing integrated food security, health and education programs that benefit 148,000 pastoralists and agro-pastoralists in Liben District, Southern Ethiopia. Liben is in a semi-arid region with erratic rainfall. Marginalized in terms of infrastructure and social services, Liben pastoralists are coping with droughts of increasing frequency and a rapidly growing population, which are stressing water and pasture resources. In Liben, water management and development are essential for human and livestock survival. Engaging communities in developing water infrastructure, building community capacity to manage resources, and integrating water management with income diversification and health interventions are central approaches to SC's program. In every community where SC undertakes water development activities, a Water Resource Management Committee is established and trained to oversee the management and maintenance of the resource, with input from the community. SC requires that 40 percent of the members of these committees are women. SC staff, with local government partners, supervise and work with Water Resource Management Committees to document activities and support effectiveness.

CONCLUSION: A truly community-based approach to water development is having positive impacts on maternal and child health outcomes as well as laying the framework for broader social change. Save the Children has been assessing the impacts on communities of water development and management activities utilizing baseline and follow-up surveys as well as focus group discussions and time use observations. The short- and medium-term positive impacts of SC's programs in Liben are clear. The rate of stunting in under-five children declined in Liben District from 54 percent in 1997 to 30 percent in 2001, despite two years of severe drought in the impact area. A total of 9,972 households and 70,000 head of livestock benefit from ponds expanded through food-for-work activities. Fourteen community Resource Management Committees have opened savings accounts to fund water point maintenance and other projects, totaling US$18,789 in December 2000. Including women on Water Resource Management Committees has resulted in developing water projects in locations that will have maximum immediate benefit for women and children, and has given women visible control over a valued community resource. This is likely to have longer-term impacts that are yet to be determined. In the coming years, SC will continue to assess how SC's community-based water development and management approach will stimulate income and asset diversification, build community capacity to jointly manage resources and work with formal financial institutions, and improve the status of women. It is these long-term impacts that address the root causes of ill health among women and children.

PHYSICAL ENVIRONMENT AND HEALTH: UNDERDEVELOPMENT

Community Development and Health

AN INTEGRATED DEVELOPMENT PROJECT ADDRESSING HEALTH IN MANICORE

Nancy Vollmer LeMay

LEARNING OBJECTIVES: Participants will understand how municipal leaders can be effective forces for change regarding health in their communities and will learn about an example of cooperation among the private sector, the municipality, the health sector and NGOs.

BACKGROUND: Manicore is the principal municipality in the State of Amazonas in Brazil. The health of the populations is severely affected by physical and infrastructure problems: no running water and poor sanitation, inadequate transportation and a limited number of health facilities (for example, one hospital). Small communities are dispersed over a very large physical area, making it hard to reach them or for them to come for services or supplies. The municipal authorities are joining with health providers and other partners to tackle these issues, as well as to link these to related issues affecting health in the community, such as income generation and environmental issues.

CONCLUSION: The first stage of the project implemented integrated development in Manicore, with maternal health as the centerpiece. An exciting element is how community leaders, health officials, women in the communities and international NGOs have worked on this in partnership. It is a good model for future cooperation on health and other issues.

PARTNER: Management Sciences for Health

ADDITIONAL AUTHORS: Susana Galdos, Manoel De Oliveira Galdino

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ROUNDTABLES

PHYSICAL ENVIRONMENT AND HEALTH: UNDERDEVELOPMENT

Community Development and Health

SALUD FAMILIAR: IMPROVING HEALTH BY IMPROVING HOUSING

Linda Jo Stern

LEARNING OBJECTIVES: Participants attending this session will be able to identify key areas of improvement for substandard housing that will, in turn, affect health status and reduce the disease burden on poor families. Participants will learn the five key principles of community organizing to enhance their success in working overseas.

BACKGROUND: Salud Familiar is a project in the mountain villages of South Central Honduras. The specific goals were improving the health status of the people in the villages and reducing the disease burden caused by environmental or vector-borne factors. The intervention included a participative community model, identification and implementation of 10 'home improvements,' and the establishment of community rural banks to continue access for the community to resources once the project was completed.

CONCLUSION: Lessons learned included emphasizing, through the technical staff, the relationship between housing and health. Other lessons were focused on the community organizing aspect. For example, improvements for the houses should be defined by a consensus of the families participating in the project; the leaders of the community should be the ones to choose the new members of the group, rather than project personnel. Other lessons learned are that home improvements are readily accepted and implemented by the community, and the 'halo' effect is dramatic, affecting their home and community pride, their level of cleanliness (which improved) and their interest in continuing with other changes in their homes and communities. Finally, the establishment of the rural bank has been an extraordinary success. This project is easily replicable in any small village where there is organization of the community, interest to do the labor and a staff/personnel who is dedicated to being there for the community.

PARTNERS: Zamorano College, Department of Socioeconomic Development and Environment, URAS/PRRAC

ADDITIONAL AUTHORS: Reyner Alberto Maradiaga, Diana Karina Fajardo, Rodney Henry Lagos, Abraham Ramirez

LEARNING OBJECTIVES: Participants will be able to describe at least four factors leading to sustainability of community participation in environmental health.

BACKGROUND: Most public health initiatives strive for sustainability. If project management and decision-making reside within the community rather than with a project office, government only or NGO, will it be sustainable? The towns in Borgou/Alibori Department, Benin experience epidemic cholera and endemic diarrheal diseases. An Environmental Health Project activity was designed to prevent transmission of diarrheal disease to children under five and also help support government decentralization. Interventions included building coalitions for environmental health at the neighborhood, municipal and departmental levels through committees that included neighbors (at the community level), members of municipal ministries, community and NGO representatives (at the municipal level), and heads of relevant departmental-level ministries, municipal committee representatives, mayors and the Prefect (at the departmental level). With municipal team facilitation, communities conducted PRA, chose microprojects, raised funds, elected neighbors to manage microproject construction and functioning, and participated in negotiated community health communication. Secondary school students observed outside community microproject latrines, counting users and observing handwashing behavior. At the end of the three-year activity, a team assessed process and sustainability.

CONCLUSION: An earlier team visit, bolstered by survey data, revealed relatively little latrine use or handwashing. The behavior observation, while not equivalent data, indicated 11,349 users of 15 community latrines during five weeks in the rainy season, when towns are depopulated as families leave to farm. The largest town had not received any monitoring or assistance in over one year when the assessment team visited. The team found a still-functioning community management committee, which had assumed management of other donors' community latrines and expanded its role to other environmental health areas. Randomly selected homes visited in Beroubouay, which had virtually no other diarrheal disease prevention education, revealed that almost everyone knew the causes and transmission of diarrheal disease and had recently implemented some preventive action. Building government, community and NGO coalitions strengthens diarrheal disease prevention interventions. Placing decision-making and management at the neighborhood level, with departmental oversight and municipal involvement, helps sustain project impact.

PARTNERS: Department of Borgou/Alibori, subprefectures and citizens of Banikoara, Sinendé, Bembéréké/Beroubouay and Parakou

ADDITIONAL AUTHOR: Salifou Yallou

PHYSICAL ENVIRONMENT AND HEALTH: UNDERDEVELOPMENT

Environmental Health Influences on Children

LINKING COMMUNITIES AND GOVERNMENT: PARTICIPATION FOR ENVIRONMENTAL HEALTH

Laurie Krieger

ROUNDTABLES

LEARNING OBJECTIVES: Participants attending this session will be able to learn about the important risk factors associated with stunting in primary school children in underdeveloped countries such as Pakistan.

BACKGROUND: Protein-energy malnutrition is one of the leading causes of childhood morbidity and mortality in developing countries. The purpose of the present study is to measure the prevalence of stunting and its correlates among the school children aged 6-12 years in the rural areas of southern Pakistan.

METHODOLOGY AND RESULTS: The study selected 1,915 children aged 6-12 years enrolled in 32 primary schools in rural Sindh, Pakistan. Trained community health workers conducted child height and weight measurements and collected information from the parents. The Z-scores for the distribution of height-for-age, weight-for-age and weight-for-height relative to those of the NCHS/CDC reference population were calculated. The study found that 300 (16.49 percent) of the 1,915 children were stunted. Female children compared to males were more likely to be stunted (odds ratio (OR)1.35; 95% confidence interval (CI) 1.05-1.72). Children older than seven years were more likely to be stunted (OR 1.46; CI 1.10-1.92). Fathers who were working as farmers (OR 1.57; CI 0.96-2.58), shopkeepers (OR 2.29; CI 1.29-4.06) and government employees (OR 1.86 CI 1.29-4.06) were more likely to have children who were stunted.

CONCLUSION: In rural Sindh, sex of child, age of the child and father's occupation are important risk factors for stunting.

PARTNERS: Department of Community Health Sciences, Aga Khan University

ADDITIONAL AUTHORS: Sayed M. Shah, B. Selwyn

PHYSICAL ENVIRONMENT AND HEALTH: UNDERDEVELOPMENT

Environmental Health Influences on Children

PREVALENCE AND CORRELATES OF STUNTING AMONG PRIMARY SCHOOL CHILDREN IN RURAL AREAS OF SOUTH PAKISTAN

Salma A. Khuwaja

PHYSICAL ENVIRONMENT AND HEALTH: UNDERDEVELOPMENT

Performance Improvement

HIGH-PERFORMING HEALTH-CARE FACILITIES IN KENYA: WHY THEY EXCEED EXPECTATIONS

Barbara Rawlins

LEARNING OBJECTIVES: The participant will be able to describe the factors that enable a health facility in a low-resource setting to exceed performance expectations, and the specific strategies used to improve and maintain performance.

BACKGROUND: Some facilities perform well even in less-than-ideal conditions. This case study documents what is working well and why, asking the question: Why are some health-care facilities resilient and able to succeed with similar resources and constraints while others are not? A sample of high-performing facilities in Kenya that offer reproductive health services was examined for factors contributing to overall high performance and resiliency, including an exploration of characteristics, behaviors and coping strategies of these facilities. The study further investigated the applicability of a performance improvement model that hypothesizes that individual and organizational performance are influenced by seven different factors: job expectations, motivation, knowledge and skills, performance feedback, facilities, equipment and supplies, leadership and management systems, and client and community focus. Most studies have focused on identifying problems and barriers preventing health-care facilities from providing quality services. This two-phase study was conducted within the framework of examining assets rather than deficits. This will allow the identification of factors influencing high performance as a means to help low or average performers make sustainable improvements.

METHODOLOGY AND RESULTS: In-depth interviews with providers, supervisors and clients at 23 facilities plus focus group discussions with community members in two facility catchment areas were conducted.

CONCLUSION: It was found that the primary factors contributing to a high-performing facility's resiliency and performance were: 1) Facilities, supplies and equipment (e.g., no contraceptive stockouts, infection prevention supplies available, appropriate laboratory tests offered); 2) management systems (e.g., cost-recovery mechanisms and autonomy for spending funds); 3) motivated and well-trained staff (e.g., 'immediate changes' was key to motivation, training, tea breaks, time off); and 4) leadership (e.g., leads by example, open communication, ability to delegate duties, honesty). Detailed findings and strategies for improving and maintaining performance validated in this study will be presented.

PARTNERS: Kenya Ministry of Health

ADDITIONAL AUTHORS: Kama Garrison, Susan J. Griffey Brechin, Pamela Lynam, Anne Njeru, Chris Rakoum

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ROUNDTABLES

PHYSICAL ENVIRONMENT AND HEALTH: UNDERDEVELOPMENT

Performance Improvement

IMPROVING INFECTION PREVENTION PRACTICES AND ENVIRONMENTAL HYGIENE IN MALAWI: A PERFORMANCE AND QUALITY IMPROVEMENT PROCESS

Debora Bossemeyer

LEARNING OBJECTIVES: Participants will be able to articulate the strength of using a holistic performance and quality improvement process to improve infection prevention practices and the environmental hygiene of hospitals in Malawi.

BACKGROUND: The Ministry of Health and Population (MOHP) in Malawi and several donors are interested in improving infection prevention (IP) practices and environmental hygiene (EH) in health facilities, thus improving the health and safety for patients and providers. According to the UNAIDS Epidemiological Fact Sheet, June 2000, the estimated HIV/AIDS prevalence among adults in Malawi in 1999 was 15.96 percent. In Lilongwe, Blantyre and Mzuzu, major urban areas, the HIV seroprevalence among antenatal women increased from 2 to 30 percent from 1985 to 1993. In 1998, 26 percent of the women attending antenatal clinics tested positive for HIV. According to Malawian MOHP representatives, the HIV/AIDS prevalence among patients in the hospitals is closer to 60 percent. In addition to HIV/AIDS, Malawi is an endemic area for tuberculosis, malaria and dengue, making infection prevention and environmental hygiene a top priority. The Performance and Quality Improvement (PQI) process for the IP/EH project has been implemented in one MOHP central hospital, one MOHP district-level hospital and one Christian Health Association of Malawi hospital. Using the PQI process and evidence-based material, IP/EH standards were developed by a multidisciplinary team of stakeholders, with input from clients. These standards have been implemented by trained quality improvement support teams for each hospital. Initial assessments of the current status of IP/EH practices in the hospitals have been established, with root causes analyzed and interventions developed. Although the MOHP and JHPIEGO are in the early stages of the project, improvements in IP/EH have already been noted. Changes such as improvements in decontamination of medical equipment, changing traffic patterns, improved handwashing, improved use of protective clothing for hospital workers and improved laundry facilities have already been documented.

CONCLUSION: Lessons learned from implementing a PQI process for IP/EH include: 1) stakeholder involvement and participatory methodologies for standards development are essential for acceptance and compliance with standards; 2) organization of standards to reflect operational processes facilitates the adoption and use of the standards by facility staff; and 3) utilization of change management strategies, such as leadership development, resource mobilization, incentives, feedback and teamwork, is required from the beginning. Additionally, there are challenges to such a participatory and holistic approach. These include continually motivating staff in low-resource environments, continually involving the clients and community in an effective and interactive way to ensure that IP/EH practices are relevant to community needs, and development of self-administered tools (job aids, self-learning materials, etc.) to ensure continued application of the national standards.

PARTNERS: Office of the Controller of Nursing Services/MOHP, Christian Health Association of Malawi, USAID

ADDITIONAL AUTHORS: Lunah Ncube, Maryjane Lacoste, Edgar Necochea

LEARNING OBJECTIVES: Participants attending this session will be able to identify the rationale for community action plans to improve the physical environment and people's health.

BACKGROUND: Kyg district had a high incidence of malaria, typhoid, dysentery and cholera. The few health facilities were poorly equipped. The only six protected water sources per subcounty served about 600 households. Most men migrated to towns in search of employment, but for the women remaining at home, culture forbade them from constructing pit latrines and wells. Diseases claimed at least 14 lives yearly. Social and health workers joined hands to assist the community to be able to identify and address these health problems.

METHODOLOGY AND RESULTS: Multistage sampling of six parishes followed. Using transect walk and resource mapping, pairwise ranking of the health problems, venn diagramming and focus group discussion, the leaders identified the causes of their community's poor health conditions. The findings were disseminated to the very community from where it was generated. The people were sensitized on the risks of unsafe drinking water, poor sanitation and the importance of women's participation. After identifying the causes of these undesirable conditions that were affecting their lives, a community action plan was put in place.

CONCLUSION: After 18 months, participatory evaluation results showed health awareness rose rapidly, from 16 percent to greater than 70 percent, and protected water sources increased by 35 percent. It was observed that children also learned hygienic behaviors from adults, and each homestead has a proper toilet. Deaths due to unsafe water and unhygienic environment are gradually decreasing. The solutions to health problems are found where the problems exist.

PARTNERS: Ruwasa Kyg District and the Church

PHYSICAL ENVIRONMENT AND HEALTH: UNDERDEVELOPMENT

Sanitation and Water Quality

COMMUNITY ACTION PLAN TO IMPROVE ON HEALTH

Priscilla Kiwumulo

LEARNING OBJECTIVES: Participants attending this session will be able to gain insights into the nature of the impending water crisis in India and what this entails for the day-to-day lives of people in India's villages.

BACKGROUND: Revised UN projections on per capita availability of annual renewable fresh water indicate that by 2025, India would reach the water stress benchmark. Uneven distribution and pollution of water resources across the country further aggravate the problem. What is the nature of the impending water crisis and what does this entail for the day-to-day lives of people in India's villages? The case studies presented in this paper seek to answer these questions.

METHODOLOGY AND RESULTS: The paper is a collection of case studies (part of a UNFPA-funded project at TERI), spanning 20 villages across India, drawing on surveys of over 350 households, focus group discussions relating to health and water resources as well as the findings of field tests of water samples. The selection of villages is based on GIS analysis of per capita water availability and study of socioeconomic characteristics. The field surveys focused on the collection and analysis of demographic and socioeconomic details, information on requirement, availability and consumption of water, with a view to gain insights into the manifestations of water stress, particularly with reference to women and children as well as possible linkages of water availability and water scarcity with local health concerns.

CONCLUSION: Based on the surveys, it appears that low water availability and poor water quality impact the lives of local people, primarily in terms of: 1) efforts in water collection, with the burden being mainly on women and children (mostly girls), and the impacts of these efforts on health; 2) time spent in water collection and the effect of this on education, income and quality of family life; 3) economic impacts, including increased expenditure and loss of income; 4) seasonal migration induced by successive seasons of crop failure; 5) health damages caused by consumption of unsafe water; 6) health damages caused by inadequate water availability and food shortage; and 7) conflicts over water, in some cases fatal. Discussions on and analysis of issues studied point to specific efforts by government and NGOs in collaboration with local communities that can help mitigate water stress, paving the way for improvement in the quality of life of the people.

ADDITIONAL AUTHORS: Shaleen Singhal, Suruchi Bhadwal, Shilpi Banerjee, G.K. Girisha, S. Sreekesh, Akram Javed

PHYSICAL ENVIRONMENT AND HEALTH: UNDERDEVELOPMENT

Sanitation and Water Quality

WATER AND QUALITY OF LIFE IN INDIAN VILLAGES

Rekha Krishnan

SOCIAL ENVIRONMENT AND HEALTH: DEMOGRAPHICS

Community-Based Outreach

COMMUNITY HEALTH AGENTS AS OUTREACH WORKERS IN HAITI

Pierre P. Despagne

LEARNING OBJECTIVES: Participants will learn about a program in which local health workers have been mobilized, trained and supported to deliver an essential package of health services to families in their communities, and are taking an active role in activities to control and prevent AIDS.

BACKGROUND: The Center for Development and Health (CDS) is a non-profit Haitian organization located in Port-au-Prince. Fourteen years after its founding in 1974 as a small dispensary in Cite Soleil, a densely populated slum, CDS had expanded its programs and facilities throughout Cite Soleil and out to other cities. In 1996, after transferring responsibility for the facilities in Cite Soleil to others, CDS became a service delivery partner of the USAID-funded HS2004 Project, and now manages one of the most comprehensive health services programs in Haiti. This program reaches almost 316,000 suburban and rural residents. CDS's population-based approach to health services involves household visits to target populations: children under five, pregnant women and tuberculosis (TB) patients. The CDS model relies on a workforce of more than 100 community-based health agents. CDS provides training and ongoing support for the health agents, each of whom monitors 500 families through frequent home visits. They have provided health education and basic services, such as immunizations, contraceptives and oral rehydration solution, and follow patients under TB treatment. They also engage in HIV/AIDS prevention activities and provide support to affected families. To ensure quality and appropriateness of care, the health agents maintain an integrated, comprehensive record-keeping system and are supervised by auxiliaries, who meet with them each month to review performance objectives and achievements.

CONCLUSION: The support of local leaders has been crucial to the success of this program. They have played key roles in identifying health agents, developing program content, facilitating meetings with local groups and motivating target groups to seek services, and have provided additional resources such as transportation for patients and use of local facilities. The lessons from this experience are applicable where local resources can impact the ability to reach underserved communities with quality health services.

PARTNERS: CDC, USAID, Hs2004 Project, Management Sciences for Health, community groups

ADDITIONAL AUTHORS: Paul Auxila, Florence Guillaume, John Pollock

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ROUNDTABLES

SOCIAL ENVIRONMENT AND HEALTH: DEMOGRAPHICS

Community-Based Outreach

IMPROVING SERVICES THROUGH A COMMUNITY-BASED INFORMATION SYSTEM

Florencio Flores

LEARNING OBJECTIVES: Participants will become acquainted with an information system that is locally maintained and used for health planning and monitoring.

BACKGROUND: Even after the devolution of health services to local government units (LGUs) in 1990, health planning in the Philippines continued to be based on targets set by the Philippine Department of Health (DOH). In 1999, the DOH put in place a community-based monitoring and information system (CBMIS) aimed at enabling health-service providers to systematically identify, categorize and prioritize women and children for selected child survival and family planning interventions. Malaybalay City, a mountain city in Mindanao, demonstrates the power of this system when it is supported by committed local leadership. The CBMIS is maintained by carefully trained volunteer health workers, who use hand-drawn maps to survey women and children in their barangays or villages. They use a simple form to record the status of each family vis-à-vis the selected health services. A rural health midwife then consolidates and compares reports from several volunteers, using the information to identify unmet needs. She works with her nurse supervisor to formulate an annual workplan, prioritizing the barangays that require the most immediate and concentrated attention. The Malaybalay City health office provides technical supervision, while the mayor's office provides logistic and administrative support. CBMIS data are shared with local officials at the village and city level during semi-annual reviews. In its third year of implementation, the CBMIS continues to guide planning and decision-making. Perhaps most notably, it has led to an increase in local government resources devoted to voluntary sterilization by allocating operating space and time at the main health center and by adding this service to outreach activities in remote villages.

CONCLUSION: Solid community support continually nurtured by good governance from experienced and effective local leadership helped make CBMIS a success in Malaybalay. Further, use of CBMIS data to guide interventions has increased the efficient use of limited resources. Other communities facing similar challenges can learn from Malaybalay's experience.

PARTNERS: Malaybalay community volunteers and health staff, Philippine Department of Health Matching Grant Program, Management Sciences for Health

ADDITIONAL AUTHOR: Grace Abad-viola

LEARNING OBJECTIVES: Participants attending this session will be able to critically evaluate the level of expertise of medical students (from the International Federation of Medical Students Associations, IFMSA) that are involved in this field, as well as to identify at least five ways that IFMSA can fight for reducing the impact of pollutants on human health.

BACKGROUND: IFMSA believes that medical students should possess the necessary competence to make sensitive and appropriate decisions based on an awareness of environmental effects on health. IFMSA has already started to act toward that goal. A very successful International Round Table Discussion (August 2001 in Aalborg, Denmark) was organized, and the International Network on Environment (INE) was created. A workshop was organized in conjunction with the 52nd General Assembly held in Taipei, Taiwan from 26 July to 2 August 2002. This workshop offered to 35 of the world's leaders of medical students a training session on pollution prevention, large group discussions on how medical students could use the IFMSA for raising awareness on the linkages between the environmental and ecosystem health and human health, small group discussions on the general status of the environment in participants' countries (seen from a medical perspective), role-playing about health problems caused by pollutants, a presentation of case studies on endocrine disrupters and a presentation of occupational and environmental diseases in Taiwan.

CONCLUSION: As tomorrow's health professionals and health administrators, medical students have an important role to play. Only through their involvement is it possible to envisage a healthier world where every patient's opinion and rights are taken into consideration. Advocating for the implementation of university courses studying the relationship between environmental pollutants and health was among the first declared immediate necessities that medical students have to take care of in the future. The final conclusions revolved around the idea of developing the International Students Network on Environment and Health and continuing, for the next year, to organize workshops, training, seminars, roundtable discussions and other types of meetings that will allow us to accomplish the goal of this workshop.

PARTNERS: Awareness Strategies for Preventing Pollutions from Industries Project, Institute of Occupational Medicine and Industrial Hygiene, National Taiwan University College of Public Health

ADDITIONAL AUTHOR: Victoria Lee

SOCIAL ENVIRONMENT AND HEALTH: DEMOGRAPHICS

Medical Community Involvement in Environmental Health

INVOLVEMENT OF MEDICAL STUDENTS IN ENVIRONMENT AND ECOSYSTEM HEALTH IN CORRELATION TO HUMAN HEALTH

Ciprian Olaru

LEARNING OBJECTIVES: Participants will be able to use new tools and methods to assess environmental health, compile community profiles, prioritize community concerns and identify targeted strategies for collaborative efforts.

BACKGROUND: Health providers are underutilized resources for promoting environmental health. The objective of the Medical Communities Project is to engage providers in gathering data that will enhance understanding of environmental health status among their service populations, leading ultimately to targeted environmental health promotion and disease prevention. New tools are being piloted that include an Environmental Health Intake Form for providers in health centers to quickly gain information about patient and community environmental health status. The results can be input into free software that maps results, incorporating additional community data. The findings have been used to advance patient health, create community profiles and identify target areas for environmental health campaigns. Partnerships have been fostered to use the data in collaborative community-based environmental health initiatives. The project is being piloted in four major urban areas int the United States (Boston, Baltimore, Chicago and New Orleans), selected to address environmental justice concerns over disproportionate risks to underserved populations and the inadequacy of existing environmental health data.

CONCLUSION: The Medical Communities Project has identified patient exposures to substances such as lead, asthma trigger factors and toxic chemicals in their immediate environment. In addition, health conditions and symptoms indicative of environmental exposures have been noted and services provided. Health centers have used this information to create community environmental health profiles and to organize collaborative initiatives. University researchers have explored possible associations between health outcomes and exposures. Piloting to date has been in urban U.S. locations, with rural sites planned. While modifications would be needed for use in international settings, the model and tools are highly relevant for utilizing existing health-care resources to generate environmental health data and foster preventive actions.

PARTNERS: John Snow, Inc. Center for Environmental Health Studies, U.S. Environmental Protection Agency, Louisiana State University, University of Maryland, neighborhood health centers, the Association of Occupational and Environmental Clinics

ADDITIONAL AUTHORS: John Pine, Odelia Funke, Darlene Boerlage, Davida Andelman

SOCIAL ENVIRONMENT AND HEALTH: DEMOGRAPHICS

Medical Community Involvement in Environmental Health

MEDICAL COMMUNITIES PROJECT: HEALTH PROVIDERS ASSESSING AND ADVANCING COMMUNITY ENVIRONMENTAL HEALTH

Terry A. Greene

ROUNDTABLES

SOCIAL ENVIRONMENT AND HEALTH: DEMOGRAPHICS

Urbanization and Health

RAGPICKING CHILDREN IN URBANIZED DEVELOPING COUNTRIES

Ravi Gupta

LEARNING OBJECTIVES: Participants attending this session will be able to understand the impact of urbanization on vulnerable children in Delhi.

BACKGROUND: One of the most devastating and complex consequences of rapid urbanization, particularly in low-income countries, is the increased number of ragpicking children (children who collect waste off streets for resale). The estimated number of children ragpickers worldwide is 30-170 million. Many of these children, mostly boys, migrate to cities from rural communities, while others have been orphaned or live with their families in the slums. All are seeking an escape from poverty. These children must resort to ragpicking to survive due to a lack of income, food and shelter. In India, estimates of street and working children vary from 10-25 million. Many cities, such as Calcutta, bear massive dumps providing hundreds of ragpickers with a daily wage. These ragpickers are especially susceptible to disease and abuse. For several years, PCI has addressed the urgent needs of the 500,000 children ragpickers in three areas of Delhi. PCI's goal has been to empower street children and to improve their life opportunities by providing a continuum of integrated services addressing their intellectual, emotional, educational, vocational and medical needs. PCI has established 'drop-in centers' (DICs), which provide weekly visits from medical professionals, sexually transmitted disease (STD), HIV/AIDS and psychosocial counseling, organized recreational activities, daily nonformal education classes, family life education and nutritional meals. A shelter home for boys has also been established to which children from the DICs are referred. To reach children outside the DICs, IEC (information, education and communication) campaigns focusing on STD and HIV/AIDS education are conducted by peer educators through street plays, rallies and puppet shows.

CONCLUSION: Using an integrated approach to counter the devastating effects of rapid urbanization in India, PCI has demonstrated results. Close to 1,800 ragpicking children have utilized DIC services, 87 children have been admitted to the shelter home, 54 children have been enrolled in the formal school system, 94 peer educators have been identified and trained, 75 children have undergone training in vocational trades, and six children have been reintegrated with their families. Fifty percent of children attending the program have seen significant improvement in their health.

ADDITIONAL AUTHOR: Janine Schooley

ROUNDTABLES

SOCIAL ENVIRONMENT AND HEALTH: DEMOGRAPHICS

Urbanization and Health

THE URBAN POOR AND HEALTH SYSTEMS IN UGANDA: FROM VOICES TO ACTION: THE CASE OF COMMUNITY INTERVENTIONS IN SOLID WASTE DISPOSAL IN KAMPALA CITY

Florence Nakanwagi Matovu

LEARNING OBJECTIVES: Participants will be able to describe factors that lead to a poor health environment for the urban poor in rapidly urbanizing countries, with specific reference to solid waste management. They will also understand how communities in deprived areas of the city are able to not only find solutions, but also can take on the authorities and make them fulfill their obligations.

BACKGROUND: In Uganda, from large cities to regional centers and small market towns, many people live in neighborhoods with little or no provision of the essential infrastructure, services and facilities essential for health. Kampala city suffers from a combination of problems associated on the one hand with rapid population growth, and on the other with disadvantaged low-income groups, poverty and failure of the municipal authorities to extend public health services to a considerable portion of the city residents. The economic crisis has in the past forced the government to cut social expenditures. This has resulted in a decline of the previously inadequate levels of investment in water, sanitation and garbage collection, especially in the poorer areas of the city. Most of the low-income household problems are further compounded by lack of space, and the residents often have to dispose of wastes in small and informal dump sites just behind their dwellings, in most cases leading to waste water channel blockage. This research focused on one significant aspect of public health – solid waste – to work toward finding solutions to the worsening of living conditions of the poor.

METHODOLOGY AND RESULTS: The research team arranged popular councils to integrate participatory research meetings into the regular council meetings. The participatory tasks were: 1) making local maps; 2) transect walks with key informants through the area of interest; 3) local histories; and 4) group interviews. These meetings included a specialist group consisting of the community representatives and the City Council officials to discuss the opportunities and problems of urban solid waste collection and disposal. Direct matrix and pairwise ranking and scoring were useful in analyzing local people's choices, practices and criteria. The criteria for community interventions were cost-effectiveness, maintenance costs, rate of accumulation, volume and weight of wastes, composition, road access, seasonal, convenience of use and market opportunities for salable waste products. The findings were presented by the research team and the community leaders during their regular local council meetings. The Kampala City Council officials, particularly those concerned with solid waste collection and disposal, and officials from other concerned ministries of local government and environment protection were invited at the final major workshop. Here, the division of labor roles between the community and the urban authorities were clearly defined within the legal framework of the urban authority.

CONCLUSION: Community innovations and sustained community participation is a function of a multifaceted process of community involvement in problem identification, discussion and community-led innovations. Individual leadership, interest and early involvement were critical factors mobilizing the community and keeping commitments on action points.

SOCIAL ENVIRONMENT AND HEALTH: HEALTH SYSTEMS

Access to Care

ACCESS TO REFERRAL CARE BY CARETAKERS OF SEVERELY ILL CHILDREN

Michael Mehari

LEARNING OBJECTIVES: Participants attending this session will be able to understand the behavioral, social, economic and cultural determinants of referral, and to assess the importance of referral compliance and its impact on child survival indicators.

BACKGROUND: Seven years after its introduction by the WHO and UNICEF, the Integrated Management of Childhood Illness (IMCI) strategy is being implemented in more than 70 developing countries. The strategy trains health workers to detect severely ill children and refer them to a higher level of care. WHO estimates that 4–36 percent of children brought to a facility in the developing world have a severe illness that may cause death and need referral. Compliance with referral is critical to IMCI's impact. Yet little is known of the social and behavioral barriers caretakers face when trying to comply with referral, as few countries have studied IMCI referral compliance in any depth.

METHODOLOGY AND RESULTS: The Ministry of Health (MOH) of Eritrea studied the barriers to referral. By reviewing more than 22,000 records, interviewing health workers and caretakers, and analyzing health information system data, a clear picture of child health referral in Eritrea was constructed. The study revealed that primary health care workers are missing 90 percent of severe illnesses needing referral. And of the cases that are referred, less than four in 10 ever make it to the referral facility. The major causes for referral were respiratory problems and trauma. Malnutrition or dehydration was not often referred. Applying a 5-percent case fatality rate to the group of referred children that did not comply, 2,000 children would be expected to die in Eritrea each year because of lack of referral care. The study revealed significant misperceptions about potential compliance with referral and the barriers faced. When complying with referral, caretakers often did so the first day (91 percent). Moderate distances (less than 4 hours) from home to referral facility did not seem to affect compliance rate.

CONCLUSION: Compliance with referral is poor and misunderstanding of referral barriers is pervasive in MOH and communities. The impact of the IMCI strategy on mortality indicators may be limited if referral issues are not addressed.

PARTNERS: USAID, Eritrea MOH, John Snow, Inc./TASC

ADDITIONAL AUTHORS: Dan Wendo, Misun Choi, Rene Salgado

SOCIAL ENVIRONMENT AND HEALTH: HEALTH SYSTEMS

Access to Care

KNOWLEDGE, ATTITUDE AND PRACTICES OF TRAINED TRADITIONAL BIRTH ATTENDANTS IN ERITREA

Abrehet Gebrekidan

LEARNING OBJECTIVES: Participants will be able to identify the role of the trained traditional birth attendants (TTBAs) and their constraints while providing the service at the community level where nurses, midwives and doctors are not adequate in number or accessible.

BACKGROUND: In Eritrea, more than 80 percent of babies are born outside of the formal health facilities. Training of the TBAs in Eritrea has been an ongoing endeavor. The study was done nationwide to evaluate the knowledge, attitude and practices (KAP) of the TTBAs and their constraints while rendering the service.

METHODOLOGY AND RESULTS: A study was carried out to identify KAP of the TTBA (trained less than one year to 20+ years) in pregnancy, labor and the postnatal period. The study set out to reach all 854 registered TTBAs reported to be active by the end of 2000. Six hundred and eighty TTBAs in the six zones of the country were reached in the study. Data were collected through validated questionnaires and focus group discussions. On identifying danger signs during pregnancy, 24 percent identified swelling of legs and face, 37 percent vaginal bleeding, and 11 percent fainting and general body weakness. During labor, 47 percent said vaginal bleeding and 46 percent said malpresentations as danger signs. Nineteen percent of the respondents admitted ever having done female genital mutilation/cut, while the majority (81 percent) had not. In general, 98 percent of the TTBAs did not have problems identifying risk conditions during pregnancy, labor and the postnatal period. The main constraints they had were shortage of supplies and lack of transportation, supervision and evaluation. Findings also indicated that TTBAs need retraining on the use of ergometrine tablets during pregnancy and checking the uterine tone and full bladder for bleeding before and after the birth of the placenta.

CONCLUSION: TBAs remain the major delivery attendants both in remote rural and in semi-urban areas, as their influence and acceptability continues to exist among the people. Training curricula need to be revised to include danger signs and measures to be taken before and while transferring the mothers. Mechanisms must be put in place for the replenishment of the TTBA kits.

PARTNERS: Ministry of Health, TASC/USAID, John Snow, Inc.

SOCIAL ENVIRONMENT AND HEALTH: HEALTH SYSTEMS

Challenges of Surgery in Developing Countries

DEVELOPING COUNTRIES: THE ART AND SCIENCE OF ORTHOPEDIC SURGERY

Edward P. Fink

LEARNING OBJECTIVES: Participants attending this session will be better able to understand the environmental conditions present in developing countries that contribute to poor health outcomes, and to recognize that medical assistance must be technologically, economically, socioculturally and medically appropriate to be sustainable.

BACKGROUND: In East and West Africa and Central and South America, medical assistance programs have been established to catalyze and augment the health sector. Intervention strategies were analyzed to determine optimal methods of administering medical assistance.

METHODOLOGY: To collect and analyze information, surveys, ethnography and field work.

CONCLUSIONS: Providing medical assistance in developing countries is not easy. Sustainable assistance requires a proper biomedical model of disease transmission, including the myriad environmental influences, and, equally important, an appreciation of the sociocultural and traditional influences on health and illness.

ROUNDTABLES

SOCIAL ENVIRONMENT AND HEALTH: HEALTH SYSTEMS

Challenges of Surgery in Developing Countries

THE UTILIZATION OF SURGICAL TECHNICIANS IN MOZAMBIQUE

Colin McCord

LEARNING OBJECTIVES: Participants will be able to describe the policy and practice related to the training of medical assistants for surgery.

BACKGROUND: In East Africa, about 10 percent of women needing cesarean section for a maternal indication actually receive one. Manpower and financial constraints obliged Mozambique to train medical assistants to perform surgical work in rural areas, where three broad priorities were identified: pregnancy-related complications, trauma-related complications and inflammatory conditions.

CONCLUSION: In Mozambique, a comparison of consecutive cesarean sections conducted by trained surgical assistants and the same number conducted by OB/GYNs indicated that the technicians' skills were sufficient to save mothers' lives. Most of the evidence concerning the quality of care provided by the surgical technicians shows that if properly trained, they can offer solutions to most emergency problems in general surgery and obstetrics.

LEARNING OBJECTIVES: Participants attending this session will be able to discuss the key components and results of a broad-based communications program for adolescents in Bangladesh.

BACKGROUND: In 1999, a coalition of partners began an innovative communication program to address the many problems of adolescents, aged 10-19 years, who constitute 26 percent of the population of Bangladesh's 130 million people. In Bangladesh, there is little recognition of adolescence as a unique period of life, and a continuing failure of public health and education systems to fully address adolescents' health and development problems. Following a detailed baseline study, a comprehensive communication package was designed and implemented consisting of question-answer booklets based on extensive adolescent input, a set of videos that were produced through participatory workshops with adolescents, reflecting the adolescent perspective, as well as comments from parents and service providers, and video user guides/life skills manuals for facilitators. These 'on-the-ground' tools are branded as the 'know yourself' communication toolkit and are tied to radio and television magazine shows under production. These mass media components are being produced with adolescent producers and spokespersons, and show adolescents searching for and finding solutions to their problems through case studies, success stories, drama, song and video/audio clips, panel discussions with experts and more. Additional communication and advocacy tools are also planned for other stakeholders.

CONCLUSION: This well-researched communication package is being adopted by various government, NGO and UN operational partners as a common toolkit for social mobilization on adolescent reproductive health issues. The strategy model recognizes that adolescents need information, need to be motivated to act, require psychosocial skills such as critical thinking and negotiation to develop positive behavioral outcomes, and need an enabling environment to foster and sustain positive change. Likewise, parents and community members also require information and motivation so that they become a part of the enabling environment. The working group will follow a demand-driven approach through strategic communication, thereby gradually influencing social norms concerning adolescent reproductive health, as well as policy and health and educational service delivery.

PARTNERS: The Adolescent Reproductive Health Working Group, USAID/Dhaka, Focus on Young Adults, the Bangladesh Center For Communication Programs, Johns Hopkins University Center for Communication Programs

SOCIAL ENVIRONMENT AND HEALTH: HEALTH SYSTEMS

Community-Based Adolescent Health Programs

ADOLESCENT COMMUNICATION FOR SOCIAL NORM AND SERVICE DELIVERY CHANGE IN BANGLADESH

Neill McKee

LEARNING OBJECTIVES: By the end of this session, participants will be able to recognize the importance of collaborating with influential community groups in promoting youth programs, and describe a process for gaining community acceptance of a program.

BACKGROUND: Nearly 500,000 refugees from neighboring countries currently reside in eleven camps in western Tanzania. Twenty-five percent are youth and adolescents. In Karago camp, UMATI implements a program aimed at improving the health and quality of life of youth. The program was designed to address the needs of youth within the camp through the provision of meaningful activities at a youth center and an outreach peer-education program.

METHODOLOGY AND RESULTS: In 2002, a review of the project, which started in 2000, identified that, in comparison to another nearby camp, girls in Karago were not active participants. Focus group discussions with community members, including parents and church leaders, identified their feelings and opinions about the youth program. Community members also offered suggestions to improve the program. In response the following were done: avoidance of certain activities, which they perceived to violate their cultural norms; introduction of the peer parent advisors group - influential parents from the community serve as the liaison between the community and the program staff; and increasing skills activities and reducing social activities that made parents think their daughters were wasting time. With the above changes, parents started to change their attitude toward the youth and adolescent program. The number of girls participating in the program increased markedly.

CONCLUSION: Collaborating with the community groups in implementing youth programs has resulted in reaching the intended group, avoiding cultural violation and ensuring community ownership of the program.

ADDITIONAL AUTHOR: Rester Boniface

SOCIAL ENVIRONMENT AND HEALTH: HEALTH SYSTEMS

Community-Based Adolescent Health Programs

LOCAL COLLABORATION FOR REFUGEE YOUTH PROGRAMS IN TANZANIA

Elisa Muhingo

SOCIAL ENVIRONMENT AND HEALTH: HEALTH SYSTEMS

Developed-Developing Country Partnerships

JAPAN'S ROLE AND CHALLENGES TO ASSIST AFRICA TO COMBAT HIV/AIDS

Osamu Kunii

LEARNING OBJECTIVES: Participants attending this session will be able to understand Japan's role and challenges to assist Africa to combat HIV/AIDS.

BACKGROUND: Since 1958, the Japanese government has been assisting in health development of African countries, including Ghana, Zambia, Tanzania and Kenya. Recognizing the catastrophic HIV/AIDS epidemic and its consequences on this continent, Japan is scaling up its assistance and collaboration in combating HIV/AIDS in Africa. A variety of Japan's oversees development agency schemes include building research institutes, hospitals and laboratories, provision of HIV rapid test kits and other medical and laboratory equipment, and technical cooperation with human resource development.

CONCLUSION: Scaling up Japan's aid in tackling AIDS/HIV in Africa, we need to seek the best mix of Japan's resources and to consolidate partnerships with recipient countries, other donors, NGOs/CSOs and the UN. Since Japan contributes to the Global Fund to Fight AIDS, Tuberculosis and Malaria, the UN Human Security Fund, World Bank policy and the Human Resources Development Fund, and others, Japan should play a more active role in coordination and collaboration of HIV/AIDS controls in Africa.

PARTNER: Japan International Cooperation Agency

ADDITIONAL AUTHOR: Hiroyuki Yakabe

ROUNDTABLES

SOCIAL ENVIRONMENT AND HEALTH: HEALTH SYSTEMS

Developed-Developing Country Partnerships

STRATEGIES FOR STRENGTHENING PARTNERSHIP PROGRAMS

Rebecca Koladycz

LEARNING OBJECTIVES: Participants attending this session will be able to identify strategies for making partnership programs more effective.

BACKGROUND: While young people throughout the Americas encounter many of the same sexual and reproductive health (SRH) challenges, there are large gaps in communication and exchange of information between organizations working in SRH in the United States and those in the southern world. Capitalizing on its extensive network of affiliates throughout Latin America and the Caribbean, the International Planned Parenthood Federation, Western Hemisphere Region (IPPF/WHR) created the three-year South-North Partnership initiative in 1998 to create a mechanism for organizations with youth programs to share experiences and gain new insights from the work of their partner organization. Through the program, 14 organizations were matched into South-North pairs. While partnerships have begun to be recognized as a strategy for addressing similar needs and sharing resources, little information is available on how to initiate partnership work. Based on IPPF/WHR's experiences in facilitating the South-North Partnership Program, this paper focuses on key issues to consider for launching partnerships and offers strategic recommendations for organizations that are involved in them. Data were collected through progress reports, the completion of trip reports after each exchange visit, and focus groups and roundtable discussions.

CONCLUSION: By sharing new ideas and approaches, partnership programs can build the capacity of SRH (and other) organizations to provide a range of high-quality services and information. While no formula exists for making a partnership successful, several key issues emerge that are important for organizations to consider when planning and implementing partnership programs. Lessons for forming partnership programs that will be addressed include organizational factors that might influence the partnership, tips for establishing partnerships based on equality and respect, considerations for involving youth in partnerships, natural phases of a partnership, what to include in a communications plan, challenges in evaluating partnerships and the role of an external agency in facilitating partnerships.

PARTNERS: PROFAMILIA/Dominican Republic, CPFH, INPPARES, LAYC, ADS, PPSA, FAMPLAN, PPNC, PROFAMILIA/Colombia, HiTOPS, BFLA, MPC, MEXFAM, FHCSD

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SOCIAL ENVIRONMENT AND HEALTH: HEALTH SYSTEMS

Drug Pricing and Access

PUBLIC SECTOR PHARMACEUTICAL PRICING: THEORY AND PRACTICE, MYTH AND REALITY

Maggie Huff-Rousselle

LEARNING OBJECTIVES: Participants will be able to examine and analyze pharmaceutical pricing strategies from multiple perspectives, including: 1) the failings of cost-recovery pricing, 2) the inadvertent fostering of public-private price competition at the wholesale level; 3) underlying incentives for institutional versus individual buyers; 4) decapitalization caused by exemption policies; and 5) the impact of overprescribing on cost/price.

BACKGROUND: The interrelated study questions were: How and why are pharmaceutical prices set in the public sector? What impact do pricing policies and practices have on purchasing behavior?

METHODOLOGY AND RESULTS: Based on a comprehensive review of previous studies and both qualitative and quantitative primary data collected in early 2002, this study raises complex, interrelated issues that support the Ministry of Health (MOH) policy debate on pricing in Ghana. Under its cash-and-carry system, the MOH created a series of revolving drug funds, from the central medical stores level, through the regional medical stores, to the final service delivery points (SDPs). Each facility is expected to replenish stock with funds from the sale of existing stock. Official pricing policies favor the upper levels, despite inefficiencies in the system. Private sector pricing is the opposite; large wholesalers with high turnover have low mark-ups and retailers with lower turnover have higher mark-ups. The pricing practices of MOH facilities have not always adhered to official policies, and these exceptions offer useful examples for those formulating policies.

CONCLUSION: These policies have had two negative consequences: 1) a more client-oriented, efficient ordering process in the private sector combined with the private sector's ability to deliver and offer lower prices have encouraged larger MOH facilities to purchase directly from private sector wholesalers; and 2) the SDP mark-up does not cover full replacement costs, and these facilities are decapitalizing. Despite higher prices and poorer service, they are often forced to buy exclusively from the MOH system because they can buy on credit there. The MOH is concerned about how poor consumers will pay for pharmaceuticals through its system. The exemption policy instituted by the MOH, while enlightened from a social equity perspective, is also effectively decapitalizing the SDP because of the long cash flow lagtime between the granting and reimbursement of exemptions. Also, the purchasing behavior of poor consumers is unlike that of the MOH facilities. Patients care about the total cost and do not typically compare the cost of a single product. They purchase most products epidosically, have little or no comparative price information and typically equate price and quality. Therefore, reducing overprescribing (4.6 items per encounter) rather than keeping SDP level mark-ups low could offer greater economic relief to patients without undermining the financial integrity of the public supply system. Conventional public sector cost-recovery approaches to pricing overlook key factors that undermine the goals of public sector pharmaceutical sales programs. A 'cost recovery' perspective encourages pricing that will 'recover' inefficiencies in the system rather than discourage those inefficiencies. It can put public sector wholesale prices above those of private sector wholesalers. It can tend to work to the benefit of the larger facilities in the supply system, while undermining operations at the service-delivery level.

PARTNER: DELIVER Project

ADDITIONAL AUTHOR: Joycelyn Azziz

SOCIAL ENVIRONMENT AND HEALTH: HEALTH SYSTEMS

Drug Pricing and Access

USING FRANCHISES TO IMPROVE ACCESS TO ESSENTIAL MEDICINES

Liza Kimbo

LEARNING OBJECTIVES: Participants will be able to describe the basics of a franchise operation, understand the potential role of a franchise operation in improving access to essential medicines in underserved populations, and describe the characteristics of a franchise operation established in a developing country.

BACKGROUND: Any franchise is a network of privately owned facilities, operating under a single brand, to replicate a uniform operating model under the supervision of a 'franchisor.' The model could theoretically be a global 'one-size-fits-all' model, such as McDonald's, or it could be tailored to national and local situations. The franchise model is a promising option for improving essential drug access because it allows for rapid start-up with a limited need for capital, and it is documented to have lower operating risks than an independently operated individual enterprise. In particular, the network can make use of economies of scale to streamline operations for the benefit of franchise operators and consumers. In an effort to improve access to essential medicines to underserved Kenyan populations, the Sustainable Healthcare Enterprise Foundation, a local NGO, has established a franchise operation for the distribution of essential medicines and supplies. The franchise presently operates 28 Child and Family Wellness Shops (CFWShops®) in the central region of Kenya (the provinces of Kirinyaga and Mbeere), with outlets operated by community health workers who have been trained in drug management, appropriate dispensing and basic business skills. The health workers operating the franchises are supervised, monitored regularly and retrained twice a year. Franchise rules are strictly enforced to ensure quality of products and services provided.

CONCLUSION: The CFWShops® experience in Kenya has demonstrated that a franchise operation can be established that will offer high-quality generic drugs at a price below that offered by other distributors and be supported by the communities in which the shops are established. Through a combination of strictly enforced supervision, monitoring and training, the availability, affordability and quality of essential medicines, as well as the quality and appropriateness of services provided, can be largely ensured.

PARTNERS: Sustainable Healthcare Enterprise Foundation, the Bill & Melinda Gates Foundation, Management Sciences for Health

ADDITIONAL AUTHOR: Denis Broun

SOCIAL ENVIRONMENT AND HEALTH: HEALTH SYSTEMS

Improving Perinatal Procedures

BLOOD BANKING POLICY: ENSURING ACCESS AND ENHANCING 'QUALITY'

Dileep Mavalankar

LEARNING OBJECTIVES: Participants will be able to identify how policies directed toward improving 'quality' of blood banking, if not well thought out, can hamper access to blood in emergency situations, thus compromising the right to life of women with complications of delivery.

BACKGROUND: Hemorrhage is the leading cause of maternal death, and blood transfusion is a lifesaving measure. Unfortunately it is one of the most neglected areas of health services in developing countries. With the emergence of HIV/AIDS, more focus has been on blood safety as one of the strategies to prevent the spread of HIV. In response to directions by the Supreme Court, the government of India issued new regulations specifying standards for licensing of blood banks with the intent to improve its quality. This presentation analyses this regulation to cull out aspects that add to the safety of blood. It shows that certain infrastructure and staffing requirements intended to improve perceived quality of blood banking are in effect acting as barriers to setting up new blood banks in rural and remote areas, thus decreasing the access to blood. Lack of blood in rural areas may contribute to delay in treatment and increasing risk of death. Thus, this analysis shows that well-intentioned blood banking policy is decreasing access to blood, which compromises women's right to life, which is a basic human right. Many developing countries are also contemplating new policies to ensure safer blood in the wake of the HIV epidemic. This analysis of blood banking regulation from India will be useful to them.

CONCLUSION: Well-intentioned policies and regulations for improving blood banking quality, if not properly thought out, can actually act as a barrier to easy access to blood transfusion. Policy should focus on ensuring safety but must take the resource situation of rural and remote areas into consideration while laying down licensing regulations for blood banks. Unnecessary infrastructure and staffing specifications can make it difficult to run small low-cost blood banks in rural areas, thus reducing access to blood and compromising women's human right to life.

PARTNERS: Indian Institute of Management, International Health Policy Program, AMDD Program of Columbia University

ROUNDTABLES

SOCIAL ENVIRONMENT AND HEALTH: HEALTH SYSTEMS

Improving Perinatal Procedures

THE DISAPPEARING ART OF ASSISTED VAGINAL DELIVERY

Patricia E. Bailey

LEARNING OBJECTIVE: At the end of the presentation, participants will be able to describe at least four reasons to advocate for renewed attention to assisted vaginal delivery.

BACKGROUND: One of the key elements in the provision of emergency obstetric care (EmOC) is assisted vaginal delivery with the use of vacuum extraction or forceps. However, recent needs assessments for EmOC in some Latin American countries, carried out under the Averting Maternal Death and Disability (AMDD) Program, show that operative vaginal delivery is rarely performed at any level of health care and no longer is taught in many medical schools. Trend data show that in most countries the cesarean delivery rate is increasing while the vaginal operative delivery rate is decreasing.

CONCLUSION: Operative delivery reduces the morbidity and risks associated with cesarean delivery while reducing the costs of obstetric care. Vacuum extraction can be taught to mid-level practitioners, such as midwives, thereby increasing coverage. In addition, assisted vaginal delivery would allow women to give birth closer to home in mid-level facilities when hospitals are not easily accessible or are overcrowded. These are all good reasons to advocate for renewed attention to assisted vaginal delivery in countries where this has been allowed to fade away.

PARTNERS: CARE, UNFPA, Columbia University Mailman School of Public Health

LEARNING OBJECTIVES: Participants will test their own assumptions about which factors most influence health-care provider performance. They will be able to relate these factors to each other and to performance outcomes, and use this new knowledge to allocate spending in resource-poor environments when multiple factors affect performance.

BACKGROUND: Improving the performance of people must begin with identifying and resolving the environmental barriers that surround them, thus enabling them to perform their best. The environmental barriers, also called performance factors, include clear job expectations, feedback, motivation or incentives, environment and tools, and knowledge and skills. Although all of these factors are necessary, we do not know which of these factors is most critical. So, with a small budget for interventions, how do you choose? Feedback? Motivation? Knowledge? PRIME II, a global health-care project that supports health-care workers in developing countries, is testing the relative effects of these factors that empower and/or inhibit performance, in Armenia, and in two other countries. The results will show how these factors relate to each other, as well as to overall performance. In this session, PRIME will present the findings of this study, and summarize results that have the greatest impact on supporting health-care workers in their work environments.

METHODOLOGY AND RESULTS: This special study is cross-sectional and draws on a random sample of over 300 providers of the same cadre (nurses, nurse/midwives) working at their service delivery points. Providers are observed carrying out a reproductive health service (i.e., prenatal care, family planning) by trained clinical data collectors who record tasks on a checklist based on the Measure Quick Investigation of Quality tool (Measure, 2001). The observer marks whether standard procedures are carried out, and then privately interviews the provider to explore each of the five performance factors (clear job expectations, feedback, motivation/incentives, environment and tools, knowledge and skills). These data sets will be entered and analyzed using EPI Info 2000 Software, making use of Statistical Package for Social Sciences for supplementary and more in-depth analysis. Additional data gathered to include in analysis were background of provider, equipment and supplies available at service delivery point, and client satisfaction through exit interviews.

CONCLUSION: The study is currently underway in Armenia and results are expected by mid-October 2002. We will be launching the study in additional countries by the end of this calendar year.

ADDITIONAL AUTHOR: Alfredo Fort

SOCIAL ENVIRONMENT AND HEALTH: HEALTH SYSTEMS

Performance Improvement for Health-Care Providers

DIAGNOSING THE PAIN OF PROVIDER PERFORMANCE

Lauren Voltero

LEARNING OBJECTIVE: Participants will be able to describe a systematic process for strengthening pre-service education.

BACKGROUND: As the environmental challenges to the health of populations continue to grow, a constant supply of well-prepared health-care providers is essential to address both their preventive and curative needs. Pre-service education is a sustainable mechanism ensuring that health-care providers have the competencies to fulfill primary health responsibilities before they begin to practice. JHPIEGO has worked in over 20 countries to strengthen pre-service education in medical, nursing and midwifery programs and improve the reproductive health skills of providers upon graduation. The incorporation of mastery learning and competency-based training as the educational standard for both classroom and clinical teaching is critical to success. To achieve this change in teaching approach as well as ensure integration of new or updated technical content, careful consideration must be given to all the factors that affect the content and delivery of pre-service education in a country. Actions must be taken at the national and institutional levels, and include both the teaching institutions and its clinical practice sites. A comprehensive process is used, beginning with efforts at the national level to gain stakeholder consensus. The focus then moves to preparing schools and clinical practice sites, revising curricula, preparing teachers and monitoring implementation. Ongoing monitoring is used to revise implementation, and finally, when resources are available, evaluation is conducted. Evaluations in countries where pre-service education has been strengthened show that pre-service education strengthening is sustained, is cost-effective and has a positive impact on service delivery.

CONCLUSION: JHPIEGO has identified and documented a systematic four-phased process for strengthening pre-service education that includes the need to address relevant advocacy and policy issues, a process for strengthening curricula, preparation for and implementation of the strengthened curricula, and evaluation of pre-service interventions. Evidence from multiple countries has demonstrated its effectiveness and sustainability, as well as its applicability to all cadres of heath-care providers and technical content areas. Lessons learned that can facilitate implementation of the process have also been identified.

PARTNERS: USAID, Ministries of Health, Ministries of Education, professional associations, teaching institutions

ADDITIONAL AUTHORS: Susan J. Griffey Brechin, Rick Sullivan

SOCIAL ENVIRONMENT AND HEALTH: HEALTH SYSTEMS

Performance Improvement for Health-Care Providers

STRENGTHENING PRE-SERVICE EDUCATION: SYSTEMATIC APPROACH AND LESSONS LEARNED

Lois Schaefer

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SOCIAL ENVIRONMENT AND HEALTH: HEALTH SYSTEMS

Public Health Issues

ACHICOPALADA: A MANIFESTATION OF DEPRESSION IN A SEMI-RURAL MEXICAN COMMUNITY

Rachel Zack

LEARNING OBJECTIVES: Participants will be able to recognize the manifestation of depression called 'achicopalada' among semi-rural Mexican women, and identify some of the triggers, emotional and physical effects, and coping mechanisms associated with this mood. Additionally, participants will learn about a quantitative and qualitative methodological approach to gathering information about the subtle distinctions used to define emotional health.

BACKGROUND: This study aimed to describe the causes, physical and emotional manifestations, and help-seeking behavior around a manifestation of depression called achicopalada in a sample of 40 women in a semi-rural community in Mexico.

METHODOLOGY AND RESULTS: The paper is based on three data collection instruments: a sociodemographic questionnaire, the Centers for Epidemiologic Studies Depression (CES-D) scale and a semi-structured interview. Forty women previously enrolled in a study conducted by the researcher's hosting agency were interviewed to assess the prevalence of depressive symptomatology and to learn about their experiences with feeling achicopalada. Analysis included a comparison of the perceptions of achicopalada between participants with high and low depressive symptomatology. Overall, the study found very high prevalence of depressive symptomatology (CES-D mean total score 24.43, standard deviation 8.6). Qualitative results showed that participants associate feeling achicopalada with a wide range of emotions, including extreme distress and a range of physical symptoms that may be quite debilitating. The triggers of feeling achicopalada included financial, marital and health problems, as well as interfamilial violence. Participants also defined actively seeking help when they do not feel well emotionally. Triangulation between qualitative and quantitative data demonstrates similarities between participants' perceptions of depression versus achicopalada. However, the participants' familiarity with the latter term indicates the importance of identifying locally acceptable terms when interviewing individuals about sensitive health information, such as mental and emotional well-being.

CONCLUSION: The use of both quantitative and qualitative methods allows for both an assessment of prevalence, duration and severity of depressive symptoms, as well as a deeper understanding of the sociocultural and interpersonal factors that contribute to the causes, manifestations and behaviors around depression in this setting. This study represents a model for formative research into the development of psychosocial interventions.

PARTNER: Instituto Nacional de Salud Publica

ADDITIONAL AUTHORS: Ann DiGirolamo, Claire Schuster

SOCIAL ENVIRONMENT AND HEALTH: HEALTH SYSTEMS

Public Health Issues

FIREARM INJURY: UNDERSTANDING AN INTERNATIONAL PUBLIC HEALTH PROBLEM

Therese S. Richmond

LEARNING OBJECTIVES: By the end of the presentation, the participants will recognize the extent of firearm injury as an international public health problem and be able to identify relevant issues for using or interpreting international firearm statistics and data.

BACKGROUND: Firearm injury is a serious public health issue, with both individual impact through mortality, morbidity, disability and broad household and community repercussions. Understanding the magnitude and distribution of firearm deaths should be part of a global public health approach, but such understanding is hampered by issues of data availability, quality and comparability. While care should be used in interpreting these data, relying only on the subset of countries with good data, without addressing the context of countries with missing or less complete data is not sufficient.

METHODOLOGY AND RESULTS: We surveyed published research and data on international firearm mortality. Available studies included total deaths by intent, population, crude and adjusted death rates. Population size and economic development classifications (or selections) often were used by these studies to categorize results. We examined the implication of expected demographic changes in population age structure, growth and urbanization. We also reviewed other issues relevant to understanding or interpreting such data, such as the presence of political conflicts, population distributions, types of weapons, firearm regulations and access and issues of pre-hospital and trauma care relevant to case fatality.

CONCLUSION: Firearm injury has a serious and disparate global impact. Estimated annual firearm deaths for the approximately fifty upper- and middle-income countries with available data, which represent less than one quarter of the total world population, totaled 115,000. Marked variations in firearm homicide by country, economic development levels, age, gender and urbanization exist, with global trends indicating increasing firearm homicide rates among poor, urban, young males. Given expected demographic trends toward increases in these populations, absolute levels of global firearm deaths can be expected to rise. Without interventions, such increases are expected to result in increases in costs through mortality, disabilities and the indirect effects of healthcare costs, quality of life and other community repercussions.

ADDITIONAL AUTHORS: Rose Cheney, William Schwab

Rebuilding Health Systems in Post-conflict Settings

LEARNING OBJECTIVES: Participants attending this session will gain a better understanding of the challenges of rebuilding health systems in areas of prolonged political and social unrest. They will be able to recognize the importance of conducting an assessment of available health services early on to establish a base for sound and rational planning to reconstruct a national health services delivery system.

BACKGROUND: Decades of war and conflict have destroyed the health services infrastructure throughout much of Afghanistan. As a first step in reconstructing the health system, the Ministry of Public Health (MOPH) needed to know what exists in order to effectively and equitably allocate limited health resources and expand services to underserved areas. At their request, a nationwide assessment of health resources was undertaken by Management Sciences for Health through the USAID-financed Afghanistan Health Services Enhancement Program. Additional donor support was provided by the European Commission, UNFPA and Japan International Cooperation Agency, and several organizations and international agencies working on the ground offered their collaboration. One hundred sixty local Afghan surveyors were identified, trained and sent out to locate and record information about available health services. The surveyors were able to access 324 out of 330 districts, compiled an inventory of services offered by 1,036 facilities and 2,950 community-based health providers, and checked 1,445 private pharmaceutical outlets for availability of key essential drugs.

CONCLUSION: Survey results have been compiled into a database which provides baseline data for evaluating coverage district by district. Use of global positioning systems and computerized mapping allow for generation of detailed maps at the province and district levels to show health facility locations in relation to population settlements and geophysical obstacles to access. This information enables the Ministry to have realistic discussions and planning sessions with provincial authorities to match local concerns and national health policies with available resources, making it possible to target areas of greatest need for specific interventions. Further, survey results enable the Ministry to hold discussions with donors about where additional investments are needed, while keeping an eye on equity in distribution, which is a primordial concern in a multi-ethnic Afghanistan.

PARTNERS: MOPH, EC, JICA, UNFPA, USAID, HANDS, Management Sciences for Health, MSH/E

ADDITIONAL AUTHORS: Feroz Ferozuddin, Scott McKeown, Saeed Osmani, Miho Sato, Randy Wilson, Ryoko Yokoyama

REBUILDING HEALTH SERVICE DELIVERY SYSTEMS: WHERE TO START?

Paul Ickx

Rebuilding Health Systems in Post-conflict Settings

LEARNING OBJECTIVES: Participants will be able to articulate some of the successful approaches and challenges involved in strengthening a government health delivery system in a post-conflict situation.

BACKGROUND: In the Ponhea Kriek District of Cambodia, near the border of Vietnam, reminders of recent civil conflict are ever-present in the heavily mined forests, frequent kidnappings and struggling health system. The Light for Life Child Survival Program (1998-2002) decreased childhood and maternal morbidity and mortality in Ponhea Kriek by building the capacity of the district Ministry of Health (MOH) to implement Expanded Program on Immunization outreach, child spacing promotion and micronutrient supplementation of reproductive-aged women and preschoolers. Light for Life also trained volunteers to lead care groups to improve the preventive and care-seeking behaviors of mothers in the areas of diarrhea, micronutrient, child spacing and immunizations. Political and MOH leaders were encouraged to support behavior change and publicly credited for progress in health indicators.

CONCLUSION: At the conclusion of Light for Life, the external evaluator found the program surpassed all its objectives. During the project period, under-five immunizable deaths dropped from 19 to three per quarter, while MOH child immunization rates rose from 5 to 81 percent. Oral rehydration treatment use increased from 46 to 80 percent, and birth spacing rose from 17 to 56 percent. The desertion rate of the 940 volunteers making 15,000 monthly home visits was only 13 percent. Although the weak infrastructure of the MOH remained a challenge throughout the project, the Light for Life staff founded a firm and cooperative link between volunteers and MOH staff, and found innovative ways (including some financial contributions, a competition, and preparing villages for EPI visits) to build the capacity of the MOH. Volunteers, the MOH staff and community leaders took pride in health status improvements, and community members report that they will continue to expect and request services from the MOH when the project term ends. Lessons learned include the necessity of flexibility and innovation in a post-conflict situation, as well as the need to sometimes provide incentives or non-renewable resources for MOH staff in a situation with few other funds available.

PARTNERS: World Relief Corporation, Cambodia MOH, USAID

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STRENGTHENING HEALTH SYSTEMS IN POST-CONFLICT SITUATIONS

Kay Hansen

SOCIAL ENVIRONMENT AND HEALTH: HEALTH SYSTEMS

School-Based Nutrition and Health Programs

CHINA SCHOOL NUTRITION PROJECT PRODUCES KEY RESULTS

Carmen Aldinger

LEARNING OBJECTIVES: Participants will be able to identify success factors and challenges of school nutrition interventions in China.

BACKGROUND: The objectives of this two-year project were: 1) to improve food intake and dietary behaviors of the target groups (students, school personnel, parents) through improved nutrition education and other school-based interventions (including changes to the physical and psychosocial school environment); and 2) to develop a model project for nutrition interventions as an entry point for the development of health-promoting schools.

METHODOLOGY AND RESULTS: This pilot project included three primary and three middle schools with a total of approximately 7,500 students and 800 teachers and staff in Zhejiang Province, China. The project was based on a document by WHO and Food and Agricultural Organization of the UN (FAO) that outlines how to foster healthy nutrition by developing health-promoting schools. Each school established its own planning group and implemented a variety of curricular and extracurricular activities, including changes in school policies, interactive learning activities, drawing and writing competitions, outreach to families and communities, and various improvements to the school environment, such as cleaning up school grounds and planting greens, and improvements of school facilities and services. Pre- and post-intervention surveys showed significant improvements in knowledge, attitudes and skills. The results varied between variables and target groups. While relevant health knowledge increased in primary and secondary students and school personnel, parents benefited the most. Attitudes about the importance of nutrition and adequate daily meals, and of HIV/AIDS education increased significantly in all pilot schools but decreased in control schools. In pilot schools, the percentage of students not drinking unboiled water and washing hands increased. School visits showed various displays of health and nutrition information on school grounds, and talks to target groups provided anecdotal evidence of individuals and families having changed their eating behavior as a result of these interventions.

CONCLUSION: This pilot project showed that school-based health and nutrition interventions resulted in various changes to the school environment and classroom instruction, which led to improved knowledge, attitudes and behavior of the target audiences and contributed to establishing health promoting schools. Success factors included supportive school management, improvements to school facilities, government support, collaboration of the school with municipality and other institutions, wide spectrum of activities and materials, student involvement in all phases, community support, involvement with parents, strong motivation, regular meetings and popularity of food/nutrition. Challenges included overwhelming need for nutrition information, need for simultaneous training for students, staff and teachers, lack of teaching/learning materials, lack of integration of nutrition education into curriculum, and inadequately developed relationships with families and communities in some cases.

PARTNERS: Health Education Center of Zhejiang Province, pilot schools, WHO, FAO

ADDITIONAL AUTHORS: Provincial working group of the Health Education Center of Zhejiang Province, including Xia Shichang, Xu Shuiyang, Zhang Xin-Wei; Tang Shu Ming, Yu Sen-Hai, Jack Jones, Peter Glasauer

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SOCIAL ENVIRONMENT AND HEALTH: HEALTH SYSTEMS

School-Based Nutrition and Health Programs

HEALTH PROMOTING SCHOOLS: CHILDREN, SCHOOLS AND COMMUNITIES IN PARTNERSHIP

Sonal Zaveri

LEARNING OBJECTIVES: Participants will be able to understand how children in poor, rural communities are important partners in change in promoting health in their schools and communities.

BACKGROUND: Children's participation is at the heart of the initiative. Most school health education models do not impact the lives of children and communities because content is irrelevant and unresponsive to social and economic realities, teachers use chalk and talk rather than child participatory active learning methodologies, and communities are not involved in the process of change. The Healthy Schools Project was initiated in 2001 in a rural district of India, involving 11 village schools, 22 teachers and about 700 children in Stds. IV, V, VI and VII. The goal of the project is to ensure active participation of children in developing the school as a model promoting good health and involving the community to identify and support health initiatives by the school. Teachers learn to implement children's participation using a simple four-step method and receive training in active learning teaching methodologies. The sustainable school health education model ensures teachers spend only 40 minutes every week using simple teaching aids, song, dance and games. Health curriculum stressed culturally acceptable, simple, environmentally friendly social and community health. Children learned about: disposal of sewage water and built simple soakage pits; decomposting and vermiculture for domestic waste; built simple latrines that do not use scarcely available water; purified drinking water without fuel using simple home purification methods; identified and controlled mosquito breeding grounds to prevent malaria; and how cheap, available food and better cooking methods enhanced nutrition.

CONCLUSION: Sensitization of district education officers, school principals and influential/elected village leaders was essential for community ownership and project sustainability and built on implementing the agency's community work. Teacher training provided information, perspective (attitude change) and technique so that teachers, accustomed to didactic teaching, promoted children's participation, overcame bias of gender and students' class and caste. The school health education model, indigenously developed, equitable and environment friendly, and built on partnership of children, schools and communities, impacted the health of children and communities.

PARTNERS: Children, community-based organization, local self-government bodies and schools

BUILDING PUBLIC HEALTH LABORATORY CAPACITY THROUGH TRAINING

Areana Quiñones

LEARNING OBJECTIVES: Participants will be able to understand the function of training for public health laboratories in combating the HIV/AIDS crisis in several sub-Saharan African countries and India, and understand the process of developing and delivering laboratory training.

BACKGROUND: The Association of Public Health Laboratories (APHL) in cooperation with the Centers for Disease Control and Prevention's (CDC) Global AIDS Program (GAP) has been working on efforts to assist with the laboratory component of the HIV/AIDS epidemic through GAP. During 2002-2003, APHL in collaboration with CDC worked toward the formation of several laboratory training teams. The three training areas that APHL is currently working on are HIV serology, laboratory management and quality assurance. APHL/CDC presented a workshop in Uganda in November 2002 on HIV serology to train an audience of laboratory managers, bench technologists and other laboratorians on best practices for HIV serology in the region. In addition, APHL developed and delivered modules for laboratory management training workshops. Modules for laboratory management training included quality systems, leadership planning, evaluation and operational management. Training in methodologies for quality assurance has also been addressed. Emphasis has been placed on quality control and external quality assurance procedures, documentation and record keeping, and basic statistics.

CONCLUSION: APHL members worked on identifying the priority training and functional needs for public health laboratories in Zimbabwe, Côte d'Ivoire, Botswana, India and other GAP countries. Following this, they evaluated current methodologies for HIV testing, related laboratory programs and best practices, and helped train laboratory scientists in HIV serology, quality assurance/quality control and laboratory management through workshops and courses designed to target laboratorians in HIV/AIDS pandemic countries. Through assisting with training in public health laboratories in sub-Saharan Africa and India, APHL has helped to strengthen the laboratory systems infrastructure to assist in the prevention of the spread of HIV/AIDS in sub-Saharan Africa and India.

PARTNERS: CDC, WHO, Ministries of Health in project countries

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HIV/AIDS RAPID SCALE-UP: THE OFFICE OF PUBLIC HEALTH AND PARTNERS IN CAMBODIA RESPOND TO INCREASED ACCOUNTABILITY

Karen A. Heckert

LEARNING OBJECTIVES: Participants attending this session will appreciate the value of partner participation and collaboration in monitoring and evaluation (M&E), and learn about a networked M&E database system.

BACKGROUND: In 2001, Cambodia was designated a rapid scale-up country for HIV prevention and care by the USAID. Increased accountability requirements accompany this designation. The USAID Office of Public Health (OPH) in Phnom Penh worked closely with nine implementing partners during an intensive planning process from March to May 2002. The process fostered increased collaboration and resulted in a set of comprehensive work plans and budgets for the $22 million Three-Year Public Health Interim Strategy launched in October 2002. The representative Monitoring and Evaluation Working Group assisted in the development of a cohesive performance monitoring plan (PMP), with a core set of indicators and targets for achieving the strategy's integrated HIV/AIDS and family health objective and its intermediate results toward increased access, improved information, improved service quality and strengthened health systems. The partners agreed to utilize uniform data collection tools to assess the relevant core indicators at both the facility-based and household levels. Periodic progress reports will be required from all partners using a specially designed ACCESS format, which provides a standard but flexible format for describing activities and specifying performance indicators and targets that will result in decreased demands for narrative reporting, fewer delayed submissions from partners for reporting progress, and improved consistency with data reporting. The partners' M&E framework will include a monitoring system whereby OPH staff conduct regular field visits to program sites to carry out an observational assessment of program progress. In addition, the National HIV surveillance system managed by the National HIV/AIDS Center for Dermatology and Sexually Transmitted Diseases was expanded to include all provinces in the seven-province focus area. To support the new PMP, the OPH received technical and financial support from the Asia and Near East Bureau to design, develop and operationalize a uniform database system that is effectively networked among all implementing partners for the duration of the Three-Year Public Health Interim Strategy.

CONCLUSION: The integrated PMP and networked database system should greatly enhance the ease of data collection, analysis and reporting to meet the rapid scale-up requirements for the expanded response to HIV/AIDS in Cambodia. The M&E framework and database system could have promising application value for neighboring countries in light of the new regional USAID office in Bangkok, Thailand, with its strong HIV/AIDS and health portfolio.

PARTNERS: CARE, FHI/IMPACT, HKI, KHANA, PFD, POLICY, PSI, RACHA, RHAC, and the Royal Government of Cambodia's Ministry of Health, the Global Health Bureau, the Asia and Near East Bureau/USAID

ADDITIONAL AUTHORS: Mark White, Chantha Chak, Daniel Levitt, Darany Dou

SOCIAL ENVIRONMENT AND HEALTH: HIV/AIDS

Community Participation in HIV/AIDS Prevention Programs

BUILDING A SUPPORTIVE COMMUNITY ENVIRONMENT FOR PREVENTION OF MOTHER-TO-CHILD TRANSMISSION SERVICES

Naomi Rutenberg

LEARNING OBJECTIVES: Participants will gain a greater understanding of how and what kinds of community involvement activities can contribute to the promotion of services for the prevention of mother-to-child transmission of HIV.

BACKGROUND: Social environments play an important role in hindering or facilitating access to health-care services. Community norms that stigmatize HIV infection are often cited as a major impediment to the successful implementation of programs for the prevention of mother-to-child transmission of HIV (PMTCT). However, if PMTCT programs address community involvement and collective action, the social environment can be tipped toward one that is supportive of PMTCT efforts.

METHODOLOGY AND RESULTS: As part of an evaluation of UNICEF's pilot PMTCT program in Zambia in May 2002, the community involvement activities were documented, six focus groups discussions were held at pilot program sites to explore community feelings and knowledge about the PMTCT program, and analogous data were collected from 46 PMTCT providers and 163 PMTCT clients. The study team identified and summarized the main themes of the discussions and compared them with client and provider knowledge and practice. Results about voluntary counseling and testing (VCT) for pregnant women and stigma are presented here.

CONCLUSION: The evaluation results suggest that PMTCT programs with appropriate community involvement activities and clinical services that respond to community views can increase positive views about VCT for pregnant women and reduce stigma. These findings need to be further explored and confirmed through a community study.

PARTNERS: Mother-to-Child Transmission Working Group, National AIDS Council Zambia, UNICEF

ADDITIONAL AUTHORS: Chipepo Kankasa, Carolyn Baek, Margaret Siwale, Sam Kalibala

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ROUNDTABLES

SOCIAL ENVIRONMENT AND HEALTH: HIV/AIDS

Community Participation in HIV/AIDS Prevention Programs

IMPORTANCE OF COMMUNITY INVOLVEMENT IN REDUCING HIV/AIDS TRANSMISSION

Navuga Robinah

LEARNING OBJECTIVES: Participants attending this session will be able to understand the role of community participation in preventing and reducing HIV transmission.

BACKGROUND: Government support and community involvement in AIDS issues has caused a dramatic decline in HIV infection in Uganda. Right from the start, AIDS organizations realized that decentralizing AIDS services to communities has invaluable advantages for successful AIDS prevention, more so given the rate of HIV infection vis-à-vis diminishing resources. In Uganda, HIV prevention has been integrated into normal activities of existing community structures, such as schools, churches, hospitals, women and youth groups, self-help groups and developmental projects. This has made it easier for communities to adopt the necessary behavior change. Advocacy, mobilization and participatory approaches were used to identify community volunteers who were trained as peer educators, community AIDS workers, counselors and trainers. A community training curriculum has been developed for community trainers to carry on the continuum of community education.

CONCLUSION: The decentralization of AIDS services has led to greater involvement of local communities in planning and implementing activities, wide coverage at a lower cost than institution-based services, enhanced sustainability of the services by involving local community members and tapping the available local resources for service delivery, government and NGO chances of reaching the most poor and vulnerable groups, and communities handling their HIV/AIDS issues more realistically and developing sustainable and effective coping mechanism as well as improving community ownership of project activities. Decentralization of AIDS resources through community-based interventions has been recognized as the most effective way of fighting the spread of HIV. In Uganda, community participation in AIDS programs is responsible for a 99 percent AIDS awareness nationwide, which is responsible for the marked decline in HIV infections.

PARTNERS: Project staff, National AIDS Control Program, AIDS service organizations

ADDITIONAL AUTHORS: Nalubowa Angela, Navuga Robinah, Tamale Moses

DISTRICT-BASED HIV/AIDS: A SOUTH AFRICAN CASE STUDY

Yogan Pillay

LEARNING OBJECTIVES: Participants attending this session will be able to appreciate how, with very limited technical assistance, stakeholders in a resource-poor setting can improve their HIV/AIDS interventions. The importance of providing assistance in the setting of achievable targets and the use of indicators to measure progress will be illustrated.

BACKGROUND: Many presenters at the International Conference on HIV/AIDS held in Barcelona in July 2002 called for an integrated approach to HIV/AIDS. However, ideas of how to establish an integrated approach and best practices were not shared. South Africa is building its health system from the bottom-up and basing it on the district health system as the vehicle to deliver primary health care. This model was used as the basis for planning and implementing a district-based approach to HIV/AIDS in one sub-district in a rural province of South Africa. First, the team drafted a document based on best practices in a few African countries, which was used as a basis to help community members, clinic committees, hospitals boards and clinic staff develop draft plans. These plans included formation of teams to cover four areas: 1) voluntary counseling and testing; 2) care for orphans and children-heading households; 3) care and support, including home-based care; and 4) prevention/awareness. A local NGO, the EQUITY project, then reviewed the draft plans and helped the teams implement the plans. At a follow-up workshop, the teams showcased an impressive list of activities. However, integration of activities and use of indicators and targets to monitor achievement were two areas that the sub-district continued to struggle with. Therefore, the team trained the teams in a second workshop and planned for additional technical assistance to sharpen the targets and indicators while tracking outputs and outcomes.

CONCLUSION: Implementing an integrated HIV/AIDS program at district and sub-district levels is possible in resource-poor settings. The lessons learned from this essential intervention is replicable in other resource-poor settings experiencing the burden of HIV/AIDS.

PARTNERS: Department of Health (Mpumalanga Province), USAID, Management Sciences for Health/EQUITY Project

ADDITIONAL AUTHORS: Alan Vos, John Bennett, Gloria Mthethwa, Constance Shongwe

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HIV/SEXUALLY TRANSMITTED INFECTION SERO-PREVALENCE AND RISK FACTOR SURVEY IN YEI, SOUTH SUDAN, 2002

Reinhard Kaiser

LEARNING OBJECTIVES: Participants attending this session will be able to learn about HIV surveillance in emergency-affected populations in South Sudan.

BACKGROUND: The impact of the long-term conflict in South Sudan on transmission of HIV and sexual transmitted infections (STIs) is not known. Baseline data are urgently needed. Formative assessments have indicated changes in sexual behavior, including start of sexual activities at younger age, increasing number of partners and more sex trade.

METHODOLOGY AND RESULTS: In November 2002, the Centers for Disease Control and Prevention will conduct a survey on HIV, syphilis and herpes simplex-2 sero-prevalence in the general population aged 15-49 years and two clinic-based samples of pregnant women and patients with STIs in Yei county, South Sudan. All participants will be interviewed with the same standardized questionnaire about knowledge, attitudes and behavioral practices regarding HIV and STIs. Results of HIV testing will be available to participants.

CONCLUSION: The survey results will guide future prevention and care strategies in Yei county. The survey will also help starting HIV voluntary counseling and testing, STI syndromic management and HIV sentinel surveillance.

PARTNERS: Centers for Disease Control and Prevention, American Refugee Committee, New Sudan National Aids Council

ADDITIONAL AUTHORS: Tekleab Kebdamo, Robert Downing, Elizabeth Marum, Bellario Ahoy, Peter Salama, Jonathan Mermin, Paul Spiegel.

SOCIAL ENVIRONMENT AND HEALTH: HIV/AIDS

HIV/AIDS Prevention for Women and Children

POVERTY REDUCTION STRATEGY FOR HIV PREVENTION AMONG WOMEN

Agnes Nansubuga

LEARNING OBJECTIVES: Participants will be able to prioritize economic sufficiency of individuals (especially women in Africa) as an essential element in any plan to reverse the spread of HIV/AIDS.

BACKGROUND: In Africa, particularly Uganda, women and girls are overwhelmingly, and increasingly, the casualties of the HIV/AIDS scourge. On average, statistics show that women are becoming infected 10 years earlier than men, basically due to unjust social factors. The economy disproportionately affects women, forcing them into prostitution and early marriages, with little or no education. The office of Women in Development in Masaka District, Uganda is funding a small grants program for innovative activities to improve the status of women in two key areas: income-generating opportunities and women's legal rights. The intervention aims at increasing access of disadvantaged women to economic opportunities as part of the broader goal of mitigating the devastating effects of the economic downturn and HIV/AIDS crisis on rural women. Grants are distributed among the targeted groups and the financial plans tailored to the specific local context rather than to donor requirements. The office offers technical assistance through training and monitoring, in conjunction with HIV/AIDS and reproductive health services.

CONCLUSION: Hundreds of women and out-of-school girls, district-wide, have participated in this economic growth and personal development program. There has been an increased level of female participation in micro and small-scale entrepreneurial enterprises. The strategy has strengthened local capacity to implement activities that generate tangible benefits, and has had an impact on the sustainability of active community participation in HIV/AIDs control and prevention activities. There is a general efficient use of scarce resources by hundreds of women, and improved services for thousands of individuals. An economically empowered society can make plans, decisions and take actions that achieve desired results, e.g., adoption of appropriate health practices.

PARTNERS: Office of Women's Development, women's local councils, community project organizations, Ministry of Health, HIV/AIDS organizations

ADDITIONAL AUTHORS: Grace Barungi, S. Mabovu, Maria Byangire

SOCIAL ENVIRONMENT AND HEALTH: HIV/AIDS

HIV/AIDS Prevention for Women and Children

WOMENS' EMPOWERMENT AND PROTECTION FROM HIV/AIDS

Saraswathi Sankaran

LEARNING OBJECTIVES: Participants will be able to prioritize programs enabling women's decision-making skills and empowerment to negotiate with husbands and avoid risks of unsafe sex.

BACKGROUND: The National Family Health Survey III, 1998-1999 and NACO 2001-2002 report: 1) a woman's life is 10 times more burdened than that of a man; 2) only 28 percent of women can decide about obtaining health care; 3) fifty percent of women in the 15-29 age group are not involved in any decision-making; 4) HIV incidence is maximum in the 15-29 age group and over 80 percent harbor misconceptions. Among 10,000 families in three slums in Chennai, India, Deepam Educational Society for Health (DESH) works to prevent women from acquiring sexually transmitted diseases (STDs)/HIV/AIDS from their spouses by educating and empowering them on decision-making skills to negotiate for safer sexual practices and improve health-seeking behavior.

METHODOLOGY AND RESULTS: Among the target population during 2000-2002, 171 groups were formed for whom 1,582 educational sessions in reproductive and child health were conducted, addressing a total of 1,720 participants, 20 community health workers (CHWs) and 880 volunteers. After 20 months of targeted intervention, 315 women respondents from an experimental group (EG) were interviewed through a systematic schedule and compared against similar interviews with 320 of a control group (CG), as well as with baseline survey (BLS) results of 318 women. Through trained CHWs and volunteers, women's health-seeking behavior improved, referrals increased from 142 in 2000 to 744 in 2001, to 1,135 in 2002. Findings for women's correct knowledge: protected sex cannot transmit HIV, EG 70 percent, CG 26 percent, BLS 28 percent; unprotected sex can transmit HIV, EG 86 percent, CG 33 percent, BLS 36 percent; I cannot ask my husband to use a condom, EG 36 percent, CG 50 percent, BLS 66 percent; no sex without condom, EG 11 percent, CG BLS 8 percent, 4 percent. Findings for the freedom of a woman's movements: permission to go out alone, EG 9 percent, CG 14 percent, BLS 23 percent; to work without getting permission, EG 32 percent, CG 20 percent, BLS 10 percent. Findings about husband's alcoholism: will patiently ignore, EG 17 percent, CG 28 percent, BLS 59 percent.

CONCLUSION: Health-seeking behavior was improved by eight times, knowledge by three times, but empowerment only marginally. Behavioral changes in 'empowerment and accountability' take a much longer time, requiring sustained efforts to convince partners on consistent condom use.

PARTNERS: The Bill & Melinda Gates Foundation, DESH

LEARNING OBJECTIVES: The Guy to Guy Project is an initiative of PROMUNDO Institute in two low-income communities in Rio de Janeiro, with the aim of engaging young men aged 15-24 years on issues of gender violence and AIDS prevention and sexual and reproductive health (SRH). The play developed by the peer promoters received an honorable mention from School of Public Health/São Paulo University in 2000 and has been presented to audiences of young people, men and women, followed by group discussions, applying activities related to the issues of gender violence and sexually transmitted infection (STI)/AIDS prevention. So far, the play was presented for more than 2,000 young people. As a result, the participants were able to learn about safer sex behaviors and reduce their misconceptions about people living with AIDS. They also share their own experiences with others.

BACKGROUND: In 1999, a pilot project was initiated to train and supervise a group of young men aged 15-24 years as peer promoters on the issues of gender violence and HIV/AIDS prevention in Rio de Janeiro. The peer promoters have developed a play and a comic book on violence against women and STI/AIDS prevention. This play has been presented in workshops for young people at schools, youth conferences, health and education governmental agencies in Rio and communities-based programs.

CONCLUSION: Work with young men on the issues of SRH and AIDS prevention is very important for them and their partners. Twenty-five percent of new AIDS cases in the world are related to young men aged 15-24 years. Their sexual behavior puts their own lives and the lives of their partners at risk. Research shows the connection between use of violence against woman and the lack of use of condoms in sexual relations. Thus, we specifically work with young men because they represent a pivotal reference for development of new social interventions aimed at changing attitudes and behaviors that, in large part, will define how they care for themselves in terms of SRH and HIV prevention and how to develop a healthy relationship with women.

ADDITIONAL AUTHORS: Gary Barker, Willer Marcondes

SOCIAL ENVIRONMENT AND HEALTH: HIV/AIDS

Reaching out to Young People about HIV/AIDS Prevention

GUY TO GUY PROJECT: ENGAGING YOUNG MEN IN GENDER VIOLENCE AND SEXUALLY TRANSMITTED INFECTIONS/AIDS PREVENTION

Marcos Nascimento

LEARNING OBJECTIVES: Participants will learn how online communities are shaping and strengthening the information exchange among youth on topics such as sexual health and HIV/AIDS prevention.

BACKGROUND: Research indicates sexual risk-taking among Latino men who have sex with men (MSM) in the United States and in Central America is quite high. Effective interventions reach this underserved population through various mechanisms. Specifically for young MSMs and GLBTs (gay, lesbians, bisexuals, transvestites), the internet is rapidly becoming an appropriate venue to exchange information and skills on reducing sexual risk behaviors. Culturally appropriate models of sexual health promotion programs are key to influencing target population. Advocates for Youth has been working with three Central American NGOs as partners in the creation of cyber cafes as safe spaces targeted to the young MSM and GLBT community, as well as an interactive web community, www.ambientejoven.org, aimed at decreasing the spread of HIV/AIDS by offering information and support to young MSMs online.

CONCLUSION: Through the use of cyber cafes and an interactive website, Advocates for Youth and three Central American NGOs have been successful in creating an online community to decrease the spread of HIV/AIDS by offering information and support to young MSMs and GBLT online.

PARTNERS: Organización De Apoyo A Una Sexualidad Integral Frente Al Sida (oasis), Guatemala; Comunidad Gay San Pedrana, Honduras; and Asociacion Entre Amigos, El Salvador

SOCIAL ENVIRONMENT AND HEALTH: HIV/AIDS

Reaching out to Young People about HIV/AIDS Prevention

THE INTERNET AS A TOOL FOR EFFECTIVE HIV/AIDS OUTREACH AMONG YOUNG LATINO MSMS AND GLBTS

Alex Franka

SOCIAL ENVIRONMENT AND HEALTH: HIV/AIDS

Using Mass Media to Educate Youth about HIV/AIDS

BEYOND MASS MEDIA: REACHING YOUTH THROUGH NEIGHBORHOOD ACTIVITIES

Koudaogo Ouedraogo

LEARNING OBJECTIVES: Participants attending this session will be able to recognize the importance of organizing neighborhood activities in HIV/AIDS multimedia campaigns targeting youth.

BACKGROUND: Many surveys in West African countries show that at least 70 percent of the young people have good knowledge of what HIV/AIDS is and its prevention means. However, their sexual behaviors expose them to HIV infection as shown by findings from a baseline knowledge, attitudes and practices (KAP) survey carried out in Côte d'Ivoire. Sixty-eight percent of youth aged 15-19 years are sexually active, and the average age of first intercourse is 16.6 years for sexually active youth. From a qualitative study among positive deviant youth who don't behave according to the common norms, it was found that the main reasons to adopt positive behavior are self-esteem, perception of self-efficacy and good communication with parents on sexual issues, etc. Based on these data and using the Zambian example, a behavior change campaign was designed targeting young girls aged 13-20 years, in Burkina Faso and Côte d'Ivoire. The campaign messages promoted the delay of first sexual intercourse, using role models. The use of mass media was combined with community-based approaches, such as identifying youth NGOs to lead local campaign committees, developing monthly activities through the local campaign committee, and advocating for community support of campaign activities and increased participation by leaders and youth. In some locations, adults guided local committees by creating neighborhood youth clubs, some of which developed income-generating activities, or awards to youth role models or young girls who did well in school. Local radios promoted the same messages, using local role models and youth positive deviants. Youth NGO representatives participated in a study tour to another youth campaign; most of those who designed the campaign were from youth NGOs; youth NGOs set up local committees in each city/town to implement the campaign activities; and technical assistance by youth was provided to the local committees.

CONCLUSION: The involvement of youth and community organizations should take place at the planning stage of interventions targeting youth, and the youth should feel that they have ownership of the intervention. Training youth to manage youth campaign activities should be integrated into the campaign development. Committees headed by adults performed better than those headed exclusively by youth.

PARTNERS: JHU/CCP, Retro-ci, PSI, National Youth Associations from Burkina and Côte D'Ivoire

ADDITIONAL AUTHORS: Claudia Vondrasek, Stella Babalola, Regina Traore, Anne Edith Kouassigan

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SOCIAL ENVIRONMENT AND HEALTH: HIV/AIDS

Using Mass Media to Educate Youth about HIV/AIDS

YOUTHSHAKERS.ORG: YOUTH ADVOCATING FOR YOUTH ONLINE

Anika Penn

LEARNING OBJECTIVES: Participants will learn strategies for leveraging the power of internet technology to create networks to further adolescent sexual and reproductive health. All participants, but particularly peer educators and youth activists, will be able to identify how to create and maintain or connect to an already existing virtual community of advocates working on sexual health and HIV/AIDS issues.

BACKGROUND: Peer education is known to be an effective strategy for educating young people about sexual health and their options. But beyond merely helping peers make informed and responsible decisions about their sexual and reproductive health, peer educators can be effective advocates for creating effective youth-friendly programs and policies at all levels. A project of both Advocates for Youth and the International Planned Parenthood Federation (IPPF), Youthshakers.org is a website designed to connect peer educators and youth activists working on sexual health issues with useful information to further their work. The site consists of: monthly features about sexual health; information about establishing and running an effective peer education program; profiles of youth-run and youth-friendly programs; an Advocacy 101 course with case studies; articles by youth activists about their campaigns; and chat rooms and list-servs on subjects from microbicides research to accessing the Global Fund. The site is youth-run and exists through contributions of information from IPPF youth council members, staff of youth-run programs in sub-Saharan Africa as well as contributions from youth activists and peer educators working at local family planning associations worldwide. The site allows young people to find strategies for launching successful advocacy campaigns at the local, national and international level, and they can join an international network of other people engaged in the same work.

CONCLUSION: Through youthshakers.org, youth activists and peer educators can enhance their skills and knowledge. By engaging in a virtual international dialogue and exchange of ideas, activists can learn how to create, change and implement effective programs and policies that further sexual and reproductive health for adolescents.

PARTNERS: IPPF Youth Council, YouthLIFE Project of CDC, Advocates for Youth

LEARNING OBJECTIVES: By the end of the presentation, participants will be able to identify the major reproductive health problems and understand the critical dearth of services for conflict-affected internally displaced persons (IDPs) in Colombia.

BACKGROUND: The Women's Commission for Refugee Women and Children and Partners conducted a reproductive health assessment in Colombia in November 2001. The purpose of the assessment was to identify reproductive health needs among the internally displaced and to advocate their access to a broad range of quality, voluntary reproductive health services.

METHODOLOGY AND RESULTS: The assessment was initiated with desktop research to determine the existing reproductive health status of Colombians and IDPs. The assessment team then traveled to Barranquilla, Bogotá, Cartagena, Quibdó and Putamayo and obtained information through observation, interviews, meetings and focus groups with IDPs, host-country and international relief representatives and donors. The Minimum Initial Services Package of reproductive health services, an international standard for the early phase of an emergency, is not available in Colombia. Sexual violence against women and girls is a weapon of war and is often unreported due to fears of retribution. Recent survey findings from the local organization PROFAMILIA show that the fertility rate among IDPs, including adolescents, is double the national rate. There are minimal to no services to prevent HIV/AIDS among IDPs, who are particularly at risk. The PROFAMILIA survey indicates that 47 percent of internally displaced women did not receive prenatal care because they cannot afford it. Pregnant internally displaced women face discrimination and rejection at hospitals for deliveries and emergency obstetric care.

CONCLUSION: The findings show that the Colombian government has abdicated responsibility to provide reproductive health care to IDPs, and there are significant reproductive health needs among the IDP population, with an alarming gap in services available to them. The most frequently reported problems included gender-based violence, adolescent pregnancies, inadequate childbirth services, particularly for complications of pregnancy and childbirth, and a lack of money for health care and medicines.

PARTNERS: Columbia University, Marie Stopes International, PROFAMILIA

ADDITIONAL AUTHORS: Therese McGinn, Claire Morris, Patricia Ospina

SOCIAL ENVIRONMENT AND HEALTH: HEALTH SYSTEMS

Health Care in Conflict-Affected Settings

CONFLICT-AFFECTED INTERNALLY DISPLACED PERSONS IN COLOMBIA LACK CRITICAL REPRODUCTIVE HEALTH SERVICES

Sandra Krause

LEARNING OBJECTIVES: Participants will be able to articulate the complexity of health-care service delivery in the West Bank and Gaza under the Israeli occupation and Palestinian intifada, describe the implications of the situation for the health of women and children, and discuss issues related to development projects operating in crisis scenarios.

BACKGROUND: Established in June 2001 as the largest health development project in the West Bank and Gaza, the USAID-funded MARAM program was designed to focus on community-based maternal and child health initiatives. In response to the severe health care challenges created by unrest in the Palestinian territories, the focus of the project shifted in April 2002 to providing emergency relief to civilians, whose access to services is often restricted by barriers to travel and infrastructural breakdowns that affect hospitals and other facilities. Rather than improving safe delivery services at primary-level facilities as planned, doctors working with MARAM have found themselves assisting in deliveries over the phone, coaching husbands and family members through the birthing process. Priorities of the relief effort include emergency obstetric care to reduce the number of deaths of laboring women in transit to hospitals, emergency medical equipment and aid for civilians, and distance learning programs to offer rapid technical support to frontline care providers.

CONCLUSION: In addition to increased risk of maternal mortality and morbidity, the escalation of conflict in the West Bank and Gaza has led to declining levels of preventive services, such as prenatal care, immunizations and family planning, and deterioration of the nutritional status of children and women. Among the obstacles to recovery are the collapse of private-sector health services and the financial, political, logistical and other constraints faced by health providers as a result of the crisis. The experiences of the MARAM project offer insight into the challenges faced by policy-makers and health planners making rapid changes in priorities during political instability, and the issues posed by shifts in focus from long-term development to short-term humanitarian assistance.

PARTNERS: USAID, Intrah (University of North Carolina School of Medicine), Pricewaterhouse Coopers

ADDITIONAL AUTHOR: Doris Youngs

SOCIAL ENVIRONMENT AND HEALTH: HEALTH SYSTEMS

Health Care in Conflict-Affected Settings

FROM DEVELOPMENT ASSISTANCE TO EMERGENCY RELIEF: MARAM RESPONDS TO THE CONFLICT IN WEST BANK AND GAZA

Umaiyeh Khammash

SOCIAL ENVIRONMENT AND HEALTH: HEALTH AND HUMAN RIGHTS

Human Rights and Women's Health

COERCIVE STERILIZATION AND SEGREGATION OF ROMA WOMEN IN SLOVAKIA

Christina Zampas

LEARNING OBJECTIVES: Participants will learn about the results of human rights fact-finding missions to Eastern Slovakia that revealed widespread discrimination and human rights abuses committed against Roma women who sought maternal health care.

BACKGROUND: The Roma, the largest racial/ethnic minority in Slovakia, have been historically subjected to various types of gynecological interventions without their consent, including coerced sterilization. The Slovak government claims that coercive sterilization practices stopped after the fall of the communist regime. However, concerns have again emerged over possible cases of recent coerced sterilization of Roma women in Eastern Slovakia. Human rights fact-finding missions in the summer and fall of 2002 investigated these allegations and uncovered pervasive abuse and discrimination in the health-care system.

METHODOLOGY AND RESULTS: Researchers conducted three fact-finding missions in Eastern Slovakia, visiting over 20 Roma settlements and interviewing over 200 Roma women. Also interviewed were hospital administrators from the hospitals serving the women from the settlement as well as the hospital's chief doctor and nurses within the gynecology department. Our findings indicate that women are being coerced by doctors to consent to sterilization under false pretenses or without full and informed consent. In addition, Roma women faced discrimination in other aspects of health care, such as being segregated from white women in hospital maternity wards and being denied access to their medical records.

CONCLUSION: The results of the fact-findings provide evidence of severe human rights violations perpetrated against Roma women in contravention to national, regional and international law and policy. The government of Slovakia has failed to live up to its international obligations to protect women's reproductive rights.

PARTNERS: Parodna (Counseling Center for Citizenship, Civil and Human Rights)

ADDITIONAL AUTHORS: Ina Zoon, Sneha Barot

ROUNDTABLES

SOCIAL ENVIRONMENT AND HEALTH: HEALTH AND HUMAN RIGHTS

Human Rights and Women's Health

FROM PRO-NATALIST TO 21ST CENTURY FAMILY PLANNING PRACTICES IN ROMANIA

Giorgiana Nicula

LEARNING OBJECTIVES: Participants attending this session will be able to understand the shift in reproductive health policies and practices, and to discuss solutions for addressing issues critical to women's health in Romania.

BACKGROUND: For decades, Romanian women have been forbidden to know about their sexual and reproductive health. In 1966, abortion was made illegal and the use of all contraception was banned as part of the regime's pro-natalistic policy. Women were expected to deliver five babies to help 'make the country strong.' Shortly after the fall of communism, abortions were legalized. Although safer, abortions continue to be used far too often as contraception. Globally, data confirm that nearly 14 percent of maternal deaths are the result of abortion. In Romania, almost twice as many infants were aborted as delivered in 1995-2000 (2,357,152 versus 1,425,349) and post-abortion care is sub-optimal. The proportion of maternal deaths due to unintended pregnancies is highest in Europe (57.8 percent versus worldwide total of 21.3 percent), a trend that is consistent with Romania. The residual effects of the previous regime and the failure of health providers to counter decades of disempowering policies have contributed to an unsafe reproductive environment for Romanian women. PCI operates a community center at a factory in Bucharest that is designed to help mitigate against these negative influences. Using an integrated, client-centered approach, the center provides counseling on sexual and reproductive health, referrals to family planning services, and education and outreach for 10,000 female factory workers. The center focuses on young women, working to build awareness and trust in a comfortable and non-threatening environment. Women are being taught to value their own reproductive health and to understand the need to now pay for essential services. Access to family planning services has increased and women are beginning to once again respect themselves and care about their sexual health in this new political and social environment.

CONCLUSION: The lessons learned through PCI's community center are being incorporated into PCI's programming, and are being shared with stakeholders (governmental and non-governmental) in Romania. The community center model has great potential for adaptation not only throughout Romania, but in other post-communist nations in this region.

ADDITIONAL AUTHORS: Janine Schooley, Elaine Himelfarb

LEARNING OBJECTIVES: Participants will understand the methods and lessons learned related to a qualitative research approach that allows researchers/programmers to learn from communities how they define rights and who has responsibilities to uphold rights of children, women and men in terms of good health, basic information that is critical in developing relevant and culturally appropriate community-based approaches to health and human rights.

BACKGROUND: Although defined from international human rights conventions and most often applied in facility settings, rights-based approaches (RBA) to health programs at the community level remain undeveloped. Exploratory research in three countries using qualitative methods was conducted to understand rights and responsibilities to uphold rights as defined by community members themselves.

METHODOLOGY AND RESULTS: Discussions using semi-structured question guides were conducted in reproductive health project sites in Ethiopia, Kenya and the Sudan, with groups representing men, women and youth (men and women). Issues included how rights were defined and who in communities had responsibilities to uphold rights of its members. Findings showed great similarities in the concept of rights, although operational definitions varied by ethnic group. Men, women and children were accorded different rights, with children's rights most consistent across the three sites. Another acknowledged issue was the unequal application of rights of women.

CONCLUSION: To begin to operationalize RBA in community-based programs, we must understand first how communities define rights and responsibilities, and which traditional structures exist and operate in promoting, protecting and maintaining rights of all community members.

PARTNERS: CARE International, Ministry of Social Affairs, Ethiopia

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SOCIAL ENVIRONMENT AND HEALTH: HEALTH AND HUMAN RIGHTS

Human Rights-Based Approaches to Women's Health

COMMUNITY-DEFINED RIGHTS AND RESPONSIBILITIES: ADDRESSING A RIGHTS-BASED APPROACHES GAP

Susan M. Igras

LEARNING OBJECTIVES: Participants will gain a familiarity with a human rights-based approach to policies that aim to reduce or increase women's fertility rates.

BACKGROUND: The size of the world's population and its implications for our global future have become an increasingly important and controversial topic. Much of this debate has focused on fertility patterns, especially the view that high birth rates are detrimental to future economic growth and the environment, and therefore should be stabilized. A key means by which states have addressed this issue is through the formulation of population policies or laws. In the wake of the International Conference on Population and Development, human rights advocates have identified problematic aspects of population policies and noted that women's reproductive rights are often disproportionately affected by such policies.

METHODOLOGY AND RESULTS: Researchers first gathered population policies from diverse countries from around the world. The researchers then engaged in a comparative analysis of these policies, identified several controversial issues that consistently appeared in the policies, and critiqued them from a human rights perspective. As a result of this critique, the researchers formulated four pillars that should guide the consideration of any population policy: human rights; a holistic reproductive health approach; advancement of women; and the rights of adolescents. The researchers also identified positive and negative country examples of policies in each of the pillars.

CONCLUSION: This paper illuminates how to respect and promote women's human rights when population policies are designed. In particular, it sets forth principles to guide the drafting and review of population policies to ensure that they respect reproductive rights.

ADDITIONAL AUTHORS: Anika Rahman, Sneha Barot

SOCIAL ENVIRONMENT AND HEALTH: HEALTH AND HUMAN RIGHTS

Human Rights-Based Approaches to Women's Health

POPULATION POLICIES AND HUMAN RIGHTS

Katherine Hall Martinez

SOCIAL ENVIRONMENT AND HEALTH: HEALTH AND HUMAN RIGHTS

Tools for Health-Care Professionals

GENDER-BASED VIOLENCE DATA COLLECTION: REVIEW OF TOOLS

Jeanne Ward

LEARNING OBJECTIVES: Participants attending this session will learn about tools to qualitatively and quantitatively assess gender-based violence among conflict-affected populations.

BACKGROUND: In 2002, the Reproductive Health for Refugees Consortium (RHRC), a group of seven international NGOs, concluded a global review of issues and programming related to addressing gender-based violence among conflict-affected populations. Consistent limitations identified by the RHRC were scant prevalence data and lack of best practices for quantitatively and qualitatively describing the nature and scope of gender-based violence in humanitarian settings.

CONCLUSION: In response to the lack of data on gender-based violence, the RHRC recently field-tested and published a manual containing tools designed to facilitate gender-based violence data collection. The presentation will review the contents of the manual, the process and rationale for the tools, and the manual's application in the field. Tools include focus group and situational analysis guidelines, as well as a draft prevalence survey. Monitoring and evaluation tools that support the documentation of service statistics will also be presented. Ethical issues related to gender-based violence assessment and data collection will be highlighted in the presentation.

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ADDITIONAL AUTHORS: Michelle Hynes, Mary Koss

ROUNDTABLES

SOCIAL ENVIRONMENT AND HEALTH: HEALTH AND HUMAN RIGHTS

Tools for Health-Care Professionals

THE PRECAUTIONARY PRINCIPLE: A LEGAL TOOL FOR HEALTH PROFESSIONALS

Maya Prabhu

LEARNING OBJECTIVES: Participants attending this session will learn the basic framework of the international legal regime related to environment and health, the significance of the precautionary principle as a legal standard to protect vulnerable systems and the potential of the precautionary principle as a tool to be used for human health advocacy.

BACKGROUND: Many issues on the international environmental health agenda are regulated in some way by the international environmental legal regime (IELR). The IELR is comprised of dozens of multilateral environmental agreements in specific areas (such as the Cartagena Protocol on Biosafety, the Stockholm Convention on Persistent Organic Pollutants and the Convention on Biological Diversity), and it is underpinned by several key legal principles. Yet, despite the relevance of the IELR to the work of health practitioners, many are unfamiliar with it and its underlying legal concepts. They are also unfamiliar with how the IELR interacts with other international legal regimes that can also impact health, such as trade and governance. As a consequence, health professionals and critical health issues can be sidelined during critical multilateral negotiations, as the WSSD process illustrated. The purpose of this paper is to provide a primer on key legal institutions and norms within international environmental law so that health professionals and policy-makers can be better advocates. In particular, this paper will discuss the 'precautionary principle.' In public health, the precautionary principle is a well-established tenet. However, it has particular meaning within international law with definitions attached to keywords such as 'serious or irreversible damage' and 'lack of full scientific certainty.' This paper will consider how the precautionary principle has evolved since the Rio Conference and consider the uses of this standard for the future human health agenda.

CONCLUSION: The precautionary principle has been used primarily to protect natural systems, and has received widespread support by the international legal community as a mediating tool to integrate often-competing economic, social and environmental goals. More recently however, debates on the precautionary principle have been most prevalent at areas of intersection between the environment, human health and biotechnology. This paper will consider the means by which the evolving IELR and the precautionary principle can be harnessed for the health agenda.

LEARNING OBJECTIVES: Those who attend the session will be able to identify at least three environmental health intervention strategies for disenfranchised communities.

BACKGROUND: Lawrence, Massachusetts is one of the oldest planned industrial communities in the United States, drawing a large immigrant population that is now more that 70 percent Hispanic. Poverty is widespread and severe, ranking the city among the twenty-five poorest in the nation, with an average per capital income of less than $10,000. Environmental health threats are significant. Lead levels in children are nearly three times the state rate and pediatric asthma rates are the highest in Massachusetts.

METHODOLOGY AND RESULTS: Casa de salud is a model for engaging community in an outreach and education effort designed to engage residents of highly stressed neighborhoods of Lawrence in activities to mitigate the health impacts of environmental exposures. Using a culturally integrated community education and organizing model, project partners developed culturally appropriate environmental health educational materials written and translated for a lay audience, trained residents to become neighborhood leaders and educators, and conducted mutual education and intervention planning among healthcare providers, scientists and community members. Using trained residents who open their homes for monthly charlas, the casas serve as the primary sites for interaction in a highly accessible setting where residents outnumber outside 'experts' and neighborhood culture is dominant.

CONCLUSION: Casa de salud demonstrates the importance of developing mutual education programs where sectors learn from each other and work together to prioritize issues affecting the community. Project partners have been able to utilize mutual education to develop more effective culturally appropriate educational materials and devise outreach and intervention strategies acceptable to the community. Further, training and supporting community residents to share environmental health information in a culturally appropriate setting has fostered greater participation by residents in mitigating environmental health threats.

PARTNERS: John Snow, Inc. Center for Environmental Health Studies, Greater Lawrence Family Health Center, Family Service, Inc., Lawrence Environmental Justice Council, Teen Coalition

ADDITIONAL AUTHORS: Serena Dee, Doris Anziani

SOCIAL ENVIRONMENT AND HEALTH: HEALTH AND HUMAN RIGHTS

Promoting Environmental Health for Disenfranchised Communities

DEVELOPING CULTURALLY APPROPRIATE INTERVENTION STRATEGIES

Gretchen P. Latowsky

LEARNING OBJECTIVES: Those who attend the session will be able to identify at least three strategies to promote mutual education among physicians and residents.

BACKGROUND: The Greater Lawrence Family Health Center (GLFHC) is a federally funded community health center serving 35,000 of the 74,000 predominately Latino residents of Lawrence, Massachusetts, the poorest city in the state and one of the poorest in the country. GLFHC providers deliver primary health care in four primary care offices, three school-based health centers and Lawrence General Hospital. There are over 70 providers, including 24 family practice residents.

METHODOLOGY AND RESULTS: In the United States, physicians traditionally receive education on preventive care, and diagnosis and treatment of illness. However, education is rare on environmental health issues and their impact. Asthma and lead are covered, but little is usually taught about fetal and early childhood environmental toxins and the actual or possible impact of environmental insults on child health and development. Teaching/learning traditionally also is done without the participation of patients and community members. Casa de salud, a model for engaging community, is an outreach and education model that engages physicians, residents, community members and researchers in a mutual exploration of local environmental hazards. These include such issues as indoor and outdoor air pollution, incinerator emissions, auto body shops and lead and mercury contamination, and engages their joint efforts to promote healthier behaviors on personal, professional, organizational, neighborhood, city and regional levels. Novel culturally appropriate teaching and strategies have emerged and will be presented.

CONCLUSION: Casa de salud demonstrates that: 1) medical education can include and be enhanced by education on local environmental health threats; 2) facilitating a collaboration between physicians, residents and community members (some of whom are also patients and staff) can be mutually beneficial; and 3) improvements occur in knowledge, behaviors and outcomes.

PARTNERS: John Snow, Inc. Center for Environmental Health Studies, Greater Lawrence Family Health Center, Family Service, Inc., Lawrence Environmental Justice Council, Teen Coalition

ADDITIONAL AUTHORS: Gretchen P. Latowsky, Doris Anziani

SOCIAL ENVIRONMENT AND HEALTH: HEALTH AND HUMAN RIGHTS

Promoting Environmental Health for Disenfranchised Communities

PROMOTING MUTUAL EDUCATION AMONG PHYSICIANS AND RESIDENTS

Serena E.H. Dee

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SOCIAL ENVIRONMENT AND HEALTH: ADOLESCENT REPRODUCTIVE HEALTH

Promoting Adolescent Reproductive Health

CREATING A SUPPORTIVE ENVIRONMENT FOR ADOLESCENT REPRODUCTIVE HEALTH SERVICES IN SHENZHEN, CHINA

Fatima Thienta Toure

LEARNING OBJECTIVES: Participants will be able to describe how adolescent reproductive health (RH) project staff worked with factory owners and volunteer associations to reach migrant youth with life-planning skills and RH services in Shenzhen, China.

BACKGROUND: The China Youth Reproductive Health Project's goal is to contribute to the improvement of the sexual and RH status of Chinese adolescents and youth aged 10-24 years. There is a significant adolescent population in China, over 300 million in total. In order to reach one of the project's main goals - creating a supportive environment for youth to enable them to improve their RH, the China Family Planning Association (CFPA) and the Program for Appropriate Technology in Health (PATH) collaborate with local family planning associations and numerous local and national organizations, both public and private. This presentation will highlight case studies compiled from findings of individual and group interviews combined with quantitative baseline and monitoring data of work done in Shenzhen with two specific community groups to reach youth with RH information and services: factory owners and volunteer associations. By working with these groups, the project was able to serve an otherwise difficult to reach group, migrant youth. The project was able to empower the youth to improve their RH status by providing information and services in a supportive environment. The case studies pay particular attention to the process of forming relationships with the factories and volunteer associations and of 'how' the project was able to work with them to build capacity to work with youth on issues of RH.

CONCLUSION: The China Youth Reproductive Health Project has been very successful in Shenzhen. The presentation will describe how and why it has been successful. Lessons and recommendations for developing the relationships and building the capacity of local groups, specifically factories and volunteer associations, will enable other programs to replicate this success. The China Youth Reproductive Health Project has already shared the lessons internally, and other sites within China have been successfully using the models to reach youth with needed RH information and services.

PARTNERS: Shenzhen Family Planning Association, CFPA, PATH

ADDITIONAL AUTHORS: Xiaojun Wang, Sujuan Li, Qian Geng, Lisa Mueller

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SOCIAL ENVIRONMENT AND HEALTH: ADOLESCENT REPRODUCTIVE HEALTH

Promoting Adolescent Reproductive Health

PROMOTING ADOLESCENT HEALTH THROUGH A SCHOLARSHIP PROGRAM

Ravaka Ranivoarianja

LEARNING OBJECTIVES: Participants will be able to link girls scholarship programs with behavior change in health.

BACKGROUND: Teenage girls and young women face special challenges in Madagascar. The education of girls is not valued and drop-out rates are very high. Female literacy rates, estimated at only 43 percent in 1993, have fallen in recent years. Almost 29 percent of girls receive no instruction whatsoever. Data show that young Malagasy girls are subjected to social pressures for early sexual encounters, leading to sexually transmitted diseases (STDs) and unwanted pregnancy. Every year, thousands of young women die from illegal clandestine abortions. A woman's level of education is positively associated with health behavior, such as condom use for protection from STDs and the use of family planning. It also correlates with the nutritional status of her children, her children's educational attainment and the overall socioeconomic status of her family. The initial goal of the project was to provide scholarships to support girls at high risk of leaving school, such as homeless, orphaned or disabled girls or girls whose families are in severe economic distress. Scholarships are awarded to handicapped students and to illiterate girls working in poorly paid factory jobs. Over time, the project has also become a powerful vehicle to transmit health messages and encourage positive reproductive health behavior. Early on, the project began recruiting and training professional women to serve as volunteer mentors for scholarship recipients. Mentors and scholarship recipients are taught about health, nutrition, adolescent reproductive health and environmental issues. In 2000-2002, 2,859 scholarships were provided and over 100 mentors were involved in the program. A pamphlet in Malagasy was produced to describe the project and various health topics. These include STD/ AIDS prevention, family planning, childhood illness, nutrition and cyclone-related health issues. A monthly meeting is organized with the recipients' parents, during which mentors provide health education. Data analysis has demonstrated that positive results have been achieved.

CONCLUSION: Such a program is especially important for Madagascar in the current post-crisis environment. Not only does it allow girls to pursue their education, it also has become an innovative activity to promote positive health behavior.

PARTNER: Jereo Salama Isika

LEARNING OBJECTIVES: Participants attending this session will be able to identify key points that should be considered when working with pharmacies as a strategy to meet the reproductive health (RH) needs of youth.

BACKGROUND: Meeting the RH needs of youth is a continuing challenge for health planners and policy-makers in Kenya. This has led to more creatively exploiting existing but under-utilized options such as pharmacies, which are frequently relied upon for health care advice, products and services. In particular, pharmacies are well placed to meet the needs of youth after they have had unprotected intercourse, including pregnancy prevention through emergency contraception (EC), prevention and management of sexually transmitted infection, and ongoing contraceptive care and counseling. Program for Appropriate Technology in Health (PATH) initiated a project where over 150 pharmacy staff from 70 pharmacies have been trained and supported to provide youth-friendly RH health services. The training curriculum was developed by PATH in collaboration with its project partners. Interpersonal communication, adolescent RH and appropriate referrals were core components of the curriculum. The communication strategy involved the development and marketing of a green 'Y' logo to promote participating pharmacies as a place to get quality care. Linked to a youth outreach strategy was the development of posters and brochures, advertising the green 'Y.' Mystery client surveys, frontline staff interviews and monitoring checklists have been essential for assessing pharmacy performance and providing supportive supervision. The project was implemented in three Kenyan cities, Nairobi, Kakamega and Mombasa. Assessments show that pharmacy staff is youth-friendly and can provide appropriate information and services. Staff awareness about EC and other RH services is high but support is needed to ensure that correct dosing and instructions are always provided. Referral links for follow-up care need to be strengthened.

CONCLUSION: Because of their accessibility and reach, pharmacies are a viable option for increasing youth-friendly service delivery outlets. Involving local professional bodies such as the Pharmaceutical Society of Kenya is instrumental for getting pharmacy participation and support. The green Y, when linked to the youth outreach strategy, has been a successful trademark for promoting youth-friendly pharmacies.

PARTNERS: Pharmaceutical Society of Kenya, Ministry of Health, University of Nairobi

ADDITIONAL AUTHOR: Rikka Trangsrud

SOCIAL ENVIRONMENT AND HEALTH: ADOLESCENT REPRODUCTIVE HEALTH

New Approaches to Improving Sexual and Reproductive Health

PHARMACIES: A VIABLE OPTION FOR MEETING YOUTH REPRODUCTIVE HEALTH NEEDS

Grace Miheso

LEARNING OBJECTIVES: Participants will be able to replicate a model of working with peer educators in urban and rural settings.

BACKGROUND: Adolescent sexual and reproductive health (SRH) is an area of critical concern in the Dominican Republic. Low use of protection during first sexual experience, high rates of teen pregnancies and low rates of condom use have a big influence on the health of Dominican youth. PROFAMILIA, the International Planned Parenthood Federation/Western Hemispere Region (IPPF/WHR) affiliate in the Dominican Republic, initiated a neighborhood-based youth peer education project to improve and strengthen community knowledge and SRH services for youth, with an emphasis on pregnancy and sexually transmitted infection (STI)/HIV prevention. The project seeks to help youth exercise their sexuality in a gratifying, mature and responsible manner, encouraging new values and attitudes about SRH that will allow youth to avoid the consequences of high-risk behaviors.

CONCLUSION: PROFAMILIA developed a number of key strategies, such as working in schools with youth, teachers, administrators and parents, partnering with other organizations to support volunteer recruitment, providing systematic and ongoing training for peer educators, distributing condoms through peer educators, and supporting peer educators in developing new avenues for their work in the community, such as radio and TV, drama groups and advocacy groups. Youth reported that peer educator trainings are strengthened by focusing less on the biological, clinical and anatomical components of pregnancy and birth control, and by incorporating more information on issues of sexuality and gender. Peer educators need to have access to comprehensive reference materials on SRH, and they require ongoing support and training. The Hablemos manual developed by PROFAMILIA has proven to be a comprehensive resource on which peer educators can rely. Project sustainability can be improved by working with a wide variety of community organizations and leaders to develop locally appropriate strategies. These organizations can be fundamental in helping to recruit, train and support the peer educators and in providing space for youth activities. Free distribution of contraceptives may not be financially feasible in the long term. However, not all youth will be able to afford to pay for contraceptives, which could ultimately have an effect on project goals. Thus, sustainability issues will need to be balanced with concerns related to access. To ensure that systematic activities are conducted, it is important to establish clear expectations and guidelines as to the kinds and numbers of activities that peer educators will carry out. Follow-up supervision and booster trainings are important in maintaining interest and appropriate levels of knowledge in peer educators.

PARTNERS: Rodolfo Coiscou, Flerida Olivo, Leopoldina Cairo, PROFAMILIA

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IAL ENVIRONMENT AND HEALTH: ADOLESCENT REPRODUCTIVE HEALTH

New Approaches to Improving Sexual and Reproductive Health

WORKING IN COMMUNITIES: YOUTH PEER EDUCATION IN THE DOMINICAN REPUBLIC

Denise Kohn

SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

Couple Participation in Reproductive Health

CONTRACEPTIVE USE AND COUPLE RELATIONSHIPS

Fernando Gonzáles

LEARNING OBJECTIVES: Participants will be able to better understand the couple dynamics related to their reproductive health.

BACKGROUND: A descriptive study was conducted in Bolivia to understand the complex couple's relationships and the power based on gender related to the decision to use a family planning (FP) method. One of the gaps is the lack of knowledge of the interventions that would be necessary to help families to achieve their reproductive needs.

METHODOLOGY AND RESULTS: From February to March 2002, a cross–sectional household survey was conducted, with 1,060 randomly selected reproductive age women and 212 male partners. The information was collected using similar questionnaires for women and their partners, and was processed using the Statistical Package for Social Sciences. To analyze the data, chi square and Student T tests were used. For the analysis, three groups of women were formed: users of modern contraceptives, users of traditional methods and non-users. The study variables (reproductive ideals, dialogue in the couple on reproductive issues, attitudes and perceptions on reproductive rights and gender roles) were compared among the three groups. Additionally, the statements of the 212 interviewed male partners were compared. The results show that the actual prevalence of contraceptive use by women's declarations is 39.6 percent modern and 17 percent traditional. Yet, as for the declaration of these same women's male partners, the prevalence is smaller: modern 23.6 percent, traditional 7.5 percent. The biggest gaps between the women's declarations and their partners are for lactation amenorrhea method (80 percent), intra-uterine device (53 percent) and rhythm (47 percent). The ideal average of children for women was 2.6, and according to them, the number is 3 for their partners. But, from the men's statement it's only 2.4. Other variables, such as the right to decide the number of children or the use of contraceptives and other aspects related to the couple's sexual life, didn't show differences among the groups. Within the differences among groups, the one that stands out is that in the women group who don't use methods, a bigger proportion of women and men think that the men are entitled to beat their wives in some circumstances, especially if she neglects the children, argues with him, refuses to have sexual intercourse or talks about sexuality topics. They say that men are also entitled to beat them if they refuse to prepare the food. The percentage of users of modern contraceptives was 33 percent, of traditional methods 66 percent, and of any method 70 percent. Moreover, more users of modern methods have been forced to have sexual intercourse (12.5 percent) than the users of traditional methods (8.6 percent) or those who don't use methods (10 percent).

CONCLUSION: The outcomes of this study pointed out specific intervention areas for reproductive health programs that look to reduce the family planning unmet needs, incorporating men as their beneficiaries.

PARTNERS: Erica Palenque, PROCOSI, Frontiers Project

SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

Couple Participation in Reproductive Health

MEN IN MATERNITY RESEARCH IN SOUTH AFRICA AND INDIA: CONTEXTUAL DIFFERENCES MATTER

Emma Ottolenghi

LEARNING OBJECTIVE: Participants will identify the potential mediating effects of specific program contexts in introducing innovative services.

BACKGROUND: The concept of 'think globally, act locally' was applied to the Population Council's study of male involvement in women's antenatal care (ANC) and postnatal care. Interventions were based on three global principles: 1) large numbers of pregnant women attend ANC services, and pregnancy implies a man's involvement, so let's involve men in maternity care; 2) providing preventive education of family planning (FP) and sexually transmitted infections (STIs) to women and men during maternity care is a good idea, so let's integrate services; and 3) key messages for behavior change can be provided through existing health-care delivery systems, so let's test this in different settings.

METHODOLOGY AND RESULTS: The interventions were tested in Kwa Zulu-Natal, South Africa and Delhi, India. Men were invited to join their partners in individual and group counseling during ANC and at six weeks postpartum. Counseling and other behavior change communication strategies were used to improve reproductive health knowledge. Results will be discussed using three examples to demonstrate how important local context is to outcomes. The first example is the importance of understanding the served population and human relationships in society. In the MiM context, age, literacy rates and partnership status make a difference. All Indian women were married, and one-third were illiterate. In South Africa, only seven percent were married, one-third live with their partners, and literacy was almost universal. The example is the need to develop BCC messages based on perceptions, self-risk assessment and actual prevalence or reproductive health conditions. In Delhi, HIV-risk behaviors appear low and prevalence among ANC women is below one percent, while in Kwa Zulu-Natal non-monogamy is acceptable and 36 percent of women are HIV-positive. FP use is higher in South Africa, but both populations have a high incidence of unplanned pregnancies. The third example is understanding the health-care delivery system, and the capacity of the system to incorporate new or modified services.

CONCLUSION: Local contexts influenced key outcomes, including reproductive health knowledge, FP use and STI/HIV preventive behaviors six months after the women's due dates.

PARTNERS: The Frontiers in Reproductive Health Program (Population Council, Family Health International and Tulane University), Employee State Insurance Corporation, Reproductive Health Research Unit and Department of Health, Kwa Zulu-Natal

ADDITIONAL AUTHORS: Leila Caleb Varkey, Anjana Das, Anurag Mishra, Mags Beksinska, Busi Kunene, Saiqa Mullick, Susan Adamchak

LEARNING OBJECTIVES: Participants attending this session will be able to: 1) explain the importance of assessing the response capacity of health facilities in the case of obstetric and neonatal emergencies; 2) describe the methodology developed in Peru to conduct response capacity assessments; and 3) apply this methodology in other resource-poor settings to determine the response capacity of various level health facilities.

BACKGROUND: Complications during pregnancy, delivery and puerperium in Peru produce high maternal morbidity and mortality rates. In order to deal with these complications, it is necessary to improve access and quality of health care as well as the response capacity of the health services. Thus, it is important to know the actual capacity of the health-care facilities to respond to these obstetric and neonatal emergencies.

METHODOLOGY AND RESULTS: In order to conduct a situational assessment of facilities' response capacity, a methodology was designed that includes: 1) an assessment guide, which evaluates the clients' opinions and the actions taken by the health facilities with regard to the patients' rights; 2) a perinatal information system (software) based on indicators, which evaluates the response capacity of essential obstetric and neonatal functions (ONF) in emergencies; and 3) a software for ONF that provides information on the facility characteristics, such as infrastructure, equipment and human resources. One of the first steps in implementing Pathfinder International's project 'Improving the Quality of Health Care Services for Obstetric and Neonatal Emergencies' was to conduct assessments using this methodology. The assessment methodology was piloted in 24 health facilities (five hospitals, nine health centers and 10 health posts), in five departments of the Peruvian jungle. The regional health directors determined the priority zones for the application of this assessment. The response capacity of the hospitals (essential functions), health centers (basic functions) and health posts (primary functions) was determined given the complexity of the emergency and considering the main indicators of maternal morbidity and mortality, such as hemorrhage, infections, gestational high blood pressure, abortion and obstructed delivery.

CONCLUSION: Overall results showed that hospitals were operating below 80 percent of the response capacity required for their level (i.e., the type of emergency that each facility level should be able to treat). Health centers were operating below 60 percent of their required capacity and health centers below 50 percent. In addition, the assessment team also identified the minimum requirements to resolve obstetric and neonatal emergencies for each type of health facility and determined the costs associated with increasing the facilities' response capacity. This assessment methodology is a low-cost technique that allows for fast application in different types of settings. After it has been processed and systematized, it allows health professionals to determine what is required for an adequate and quality response to various types of obstetric and neonatal emergencies.

ADDITIONAL AUTHORS: Miguel Gutierrez, Jhony Juárez, Enrique Guevara

SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

Emergency Obstetric and Neonatal Care

DETERMINING RESPONSE CAPACITY IN OBSTETRIC AND NEONATAL EMERGENCIES

Alfonso Villacorta Bazan

LEARNING OBJECTIVES: Participants will be familiar with barriers that women with obstetric complications in Bangladesh face accessing quality emergency care, and the success of program interventions to remove these barriers.

BACKGROUND: In a society that is poor, strongly patriarchal and where women's status and self-esteem is far from ideal, the socioeconomic environment strongly influences the care-seeking behavior, the behavior of service providers and the general state of the services for women. The whole domain of care during pregnancy and delivery is seen as one for which the popular section (family) is primarily responsible. Typically the rural woman (girl) is married before 18 years of age, and her knowledge and behavior is based on prevailing wisdom and tradition. This contributes to the following as reported in the recent maternal health survey: 1) less than 50 percent of women avail even a single antenatal care check; 2) more than 90 percent of births take place in the home, mostly in unhygienic conditions; 3) a family member, neighbor or relative is the birth attendant for roughly 60 percent of births; and 4) close to 30 percent of births are conducted by traditional birth attendants (TBAs), many using harmful practices.

METHODOLOGY AND RESULTS: There has been an encouraging improvement of the critical process indicators of the availability and utilization of emergency obstetrical care (EmOC). A comparison has been made of the process indicators in 1994 and 1999. The coverage of both basic and comprehensive EmOC services has increased from 1 per 3.6 million population to 1 per 1.9 million population. Comprehensive EmOC is available in 60 percent of district hospitals and 3 percent of Upazila health complexes. The met need of EmOC (proportion of women with obstetric complications treated at facilities) increased from 5 to 27 percent. The percentage of births conducted in facilities has increased from 2.2 to 8.3 percent. Caesarean section rate has increased from 0.7 to 2.2 percent.

CONCLUSION: Many factors contribute to the prevailing high rate of maternal mortality by acting as barriers to the uptake of services when a woman develops life-threatening complications. Strategies have been designed and implemented that have increased the availability and utilization of life-saving services for women with obstetric complications.

PARTNERS: Government of Bangladesh, UNICEF, AMDD Program of Columbia University

SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

Emergency Obstetric and Neonatal Care

INEQUALITIES IN ACCESS TO HEALTH CARE: THE CRISIS OF EMERGENCY OBSTETRIC CARE IN BANGLADESH

Yasmin Ali Haque

ROUNDTABLES

SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

Family Planning Models

BIRTH-SPACERS: AN UNDERSERVED POPULATION FOR FAMILY PLANNING

William H. Jansen II

LEARNING OBJECTIVE: Participants attending this session will appreciate the unmet need for birth spacers.

BACKGROUND: Demographic and health survey (DHS) data were used to investigate the levels of met and unmet need for family planning for birth spacing and limiting.

METHODOLOGY AND RESULTS: To better understand the relationship between demand for family planning, the desire to space or limit births, and other variables such as age and parity, PRIME II conducted an analysis of demand for and unmet need for family planning. The motivation to take an in-depth look at this topic arose from several questions: How much of demand for family planning is due to spacing and how much is due to the desire to limit births? How does demand for spacing or limiting relate to age, parity and other variables? What is the potential for future demand? Are there differences in met need for spacing and met need for limiting? DHS data from 15 developing countries in Asia, Latin America and Africa on use and demand for family planning both to space births and to limit births were analyzed and compared for married women of reproductive age (MWRA). The analyses focused on the influence of age and parity on demand for spacing and limiting and the use of specific family planning methods. Differentials in met need for spacing versus limiting were also examined. The analyses demonstrated a sharply defined 'x' pattern where demand for limiting supplanted demand for spacing based on the age and parity of women. The age and parity levels at which this switch occurred varied, often substantially, among the countries included in the study. The study also uncovered large differences in the levels of met need for spacing and limiting among countries.

CONCLUSION: This research has important implications for how providers are trained, and how they tailor messages to clients to best meet their needs.

ADDITIONAL AUTHORS: Rich Mason, Dianna Frick

SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

Family Planning Models

QUALITY IMPROVEMENT PROCESS: TOGO'S MODEL ZONE EXAMPLE

John Dodji Agbodjavou

LEARNING OBJECTIVES: Participants attending this session will be able to identify key activities, results and lessons learned from the Togo model quality zone experience, and establish the difference between the process in rural versus urban environments.

BACKGROUND: The Family Health and AIDS Project (FHA) established a model quality zone in Togo to demonstrate the application of a continuous quality improvement approach in using family planning services. Emphasis was placed on work methods while giving priority to both the client's concerns and constantly improving work conditions. Ten family planning health districts, situated in both rural and urban settings, were selected to form the model zone. Key activities include: 1) initiation of a quality improvement process that was carried out via reinforcing service providers, community representatives and health district quality team members' competencies in quality assurance; 2) establishment of quality assurance structures, such as quality assurance teams composed of health personnel and community members in the health centers and quality advisors at the health district level; 3) development and reinforcement of quality team members' clinical competencies and interpersonal communication; 4) follow up and support of the teams in using quality management tools and the problem solving process; 5) regular external supervision supported by internal supervisions. The teams' performance was evaluated by follow-up visits and supervisions during periodic meetings, quality management tools and a quality improvement cycle. A significant number of problems were identified and locally resolved by the teams in the centers. These problems were related to the providers' competence, organization, service management, reception, communication, infection prevention techniques and improved work conditions. The process has a certain effect on performance that is transformed by the provider's behavior change, manner of designing and conducting work and improved relations between the health personnel and the community members. A certain culture of quality is progressively developed and the approach is well received and accepted by the group of partners. However, it should be noted that the process in the urban environments is not developed in the same method as in the rural ones. In urban environments, the implication and the community commitment were not totally effective. The quality team meetings are not regular, as the community representatives had other preoccupations and are not always available. The mobilization of community resources is more difficult. The majority of the problems identified by the urban center teams require more resources to resolve. The benevolent who support the work of the team community members are not always well received.

CONCLUSION: Community involvement is crucial to the improvement of the quality of service process in rural areas. In the urban areas, this involvement is more difficult to manage and needs other strategies to ensure the quality of services.

PARTNERS: Community networks, project staff

ADDITIONAL AUTHOR: Paul Heodom Sossa

LEARNING OBJECTIVES: Participants will learn the findings of operations research measuring the effectiveness of a community-based female genital cutting (FGC) abandonment model that integrated FGC activities into ongoing reproductive health (RH) project activities.

BACKGROUND: The prospective research study using a semi-experimental design tested the effectiveness of community-based education and advocacy activities in changing men and women's knowledge, attitudes, beliefs and intent to continue the practice of FGC.

METHODOLOGY AND RESULTS: CARE added FGC abandonment activities to ongoing community-based RH projects in Ethiopia and Kenya that were operating in communities in which the practice of infibulation was universal. Prior to adding FGC abandonment activities in the projects, baseline knowledge, attitude and practice (KAP) surveys focusing on health, social and human rights issues were conducted in 2000 in intervention and comparison areas. The same instrument was applied in 2002 after 18 months of the FGC abandonment interventions to measure changes in KAP. The presentation will focus on results of the operations research and key methodological issues in conducting survey research on a sensitive, culturally condoned practice.

CONCLUSION: Very little research exists that tests the effectiveness of program models to work with communities to inform, encourage public debate and eventually decide whether the harmful but traditional practice of FGC should continue in the communities. The research results will show how an integrated RH-FGC program model was effective in two different settings.

PARTNERS: CARE International, the Population Council (Frontiers Project), local researchers in the two countries

ADDITIONAL AUTHORS: Susan Igras, Jane Chege

SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

Female Genital Mutilation

EFFECTIVENESS OF FEMALE GENITAL CUTTING ABANDONMENT ACTIVITIES IN ETHIOPIA AND KENYA

Jacinta Muteshi

LEARNING OBJECTIVES: Participants attending this session will be able to identify three potential reasons behind the changing attitudes of Pokot communities to the issue of female genital mutilation.

BACKGROUND: Traditionally by age 18 years, nearly all Pokot young women in Kenya will have been circumcised as part of their rites of passage into adulthood and readiness for marriage. Also known as female genital mutilation (FGM) or female genital cutting, female circumcision is widely accepted in 28 countries of Africa and Asia. An estimated 130 million women worldwide are circumcised. FGM poses numerous health risks to women, beginning with the process of excision of healthy tissue. The operation can cause hemorrhage, infections, severe scarring, fistula formation and various difficulties in urination, menstruation, sexual intercourse and childbirth. Because the Pokots practice the most severe form of FGM, complications in their most severe forms are also well known. In spite of many years of legal and medical pronouncements against FGM, the practice has persisted, largely because of the support to the practice from both men and women who believe it has a role to play in diminishing libido and thereby promoting chastity and fidelity. In 1999, World Vision started a campaign among the Pokots of Marich Pass to reject the practice as part of the community's own rite of passage into the new millennium.

CONCLUSION: As of this year, the usual 300 girls participating in FGM camps were down to 50, tangible evidence of a potential trend of a community's abandonment of a harmful practice. The principal reasons for the change that could be the template of similar programs elsewhere are a combination of the following: 1) recognition that FGM is a cultural tradition that is embedded in an ethnic group's identity, value system and priorities related to sexuality, courtship and family; 2) ownership of the need for change from within the girls themselves, and the women who were performing the practice; 3) vocal and aggressive support from Pokot opinion leaders; 4) Kenya's economic downturn, as the celebration after the circumcision camp could be the equivalent of a head of household's salary for the year; and 5) emerging risks related to HIV/AIDS exposure.

PARTNERS: Pokot communities

ADDITIONAL AUTHOR: Milton B. Amayun

SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

Female Genital Mutilation

REDUCING FEMALE GENITAL MUTILATION

Fatuma Hashi

ROUNDTABLES

SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

Health Improvements for Refugees

IMPLEMENTING REPRODUCTIVE HEALTH PROGRAMS ALONG THE THAILAND-BURMA BORDER

Cynthia Maung

LEARNING OBJECTIVES: Participants will be able to identify challenges and opportunities to implementing reproductive health (RH) programs in an environment where beneficiaries and key implementing organizations do not have legal status, and health workers do not have formally recognized training. Participants will also learn how to effectively implement reproductive health programs by coordinating with partner organizations.

BACKGROUND: Although the Mae Tao Clinic is not registered, it has emerged as the lead coordinating body for RH programming activities along the Thailand-Burma border. Through establishing contacts and coordinating projects with local ethic groups, NGOs and the Thai Ministry of Public Health (MOPH), the Mae Tao Clinic has sought opportunities to strengthen RH services to illegal migrant workers in Thailand and internally displaced persons (IDPs) from Burma. Unregistered local ethnic groups recognized both the challenges and the opportunities to implementing RH programs. While local ethnic groups are the ideal people to conduct RH programs in their community, they are often unable to do so due to their legal status. Consequently, much needed outreach programs are virtually non-existent because health workers fear arrest and deportation. However, a benefit of not having official recognition is that local ethnic organizations are able to administer cross-border projects and conduct educational and training programs with few policy restrictions. Coordinating with other groups is an important component of delivering RH services. In 2002, the Mae Tao Clinic coordinated with two local ethnic groups to develop a curriculum and train staff to implement an adolescent RH project. In the future, the MOPH, with technical assistance from the international organization for migration, plans to work with the local ethnic groups to deliver health services to migrant workers.

CONCLUSION: Working with unregistered status can both benefit and hinder the activities of implementing organization. By working to strengthen ties with potential partners in the community, the Mae Tao Clinic continues to improve the delivery of comprehensive RH services to illegal migrant workers in Thailand and IDPs in Burma.

PARTNERS: Local ethnic groups, NGOs and Thai MOPH

ADDITIONAL AUTHORS: Tara M. Sullivan, Sophia

SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

Health Improvements for Refugees

RESEARCH FOR POLICY: LINKAGES TO IMPROVE REFUGEE HEALTH

Sara Casey

LEARNING OBJECTIVES: Participants will gain an appreciation of the benefits and challenges inherent in active collaboration among research and service agencies in the humanitarian field.

BACKGROUND: Linkages between research entities on the one hand and relief agencies on the other are becoming more common in humanitarian response. One such active partnership is the Reproductive Health for Refugees Consortium, a collaboration among seven agencies of varied type and with varied missions. This paper discusses the changes required within the partnership and within the individual member agencies due to increased attention to data collection and use at organizational, country and project levels.

METHODOLOGY AND RESULTS: Data on organizational policies and processes, staff skills and field procedures regarding program design and collection and use of data were collected using self-administered semi-structured questionnaires, ongoing observation and monitoring of selected field projects, and key informant interviews.

CONCLUSION: The analysis suggests that there is substantial interest and some success in using an evidence-based approach to programming among humanitarian agency partners. There also exist, however, several factors in the history, culture and structure of the humanitarian field that are not conducive to the deliberate and reflective process of conducting research, especially as a preliminary step to establishing services. These factors, which include the organizations' fundamental purposes, staff strengths and longevity, and funding sources and cycles, are discussed. Suggestions for steps that could be taken to further improve linkages between the research and service communities are offered.

PARTNER: Reproductive Health for Refugees Consortium

ADDITIONAL AUTHOR: Susan Purdin, Therese McGinn

CHANGING THE SOCIAL ENVIRONMENT TO FOSTER MALE INVOLVEMENT IN ANTENATAL CARE IN ZIMBABWE

Ravai Marindo

LEARNING OBJECTIVES: Participants will be able to describe the barriers and enabling factors in changing the social environment to foster men's participation in their partner's antenatal care (ANC) and pregnancy, how this information was used to inform a clinic and community-based intervention, and the effects of the intervention on male attendance at ANC.

BACKGROUND: Pregnancy represents a time of vulnerability for women and their babies with respect to sexually transmitted infections (STIs), including HIV. These infections during pregnancy can have adverse effects on the health of the mother and the health of the child. But pregnancy may also be an opportunity to engage pregnant women and their partners in the ANC setting on ways to reduce STI/HIV risk by capitalizing on both members' interest in protecting the health of their child.

METHODOLOGY AND RESULTS: Researchers conducted 37 focus groups with men, women and health workers to explore notions and desirability of male involvement, and used this information to develop an outreach component in a commercial farming area. To evaluate the effects on male involvement and other variables, process and survey data were collected from pregnant women and their partners (approximately 300), outreach workers and nurse-midwives. Interest in male involvement was widespread. But men and women differed on what constituted male involvement during pregnancy. Both expected men to provide financial support but women wanted men to come to the clinic more often than the men wanted. Men feared loss of respect from peers if they did so. To address this barrier, the project was named 'Mira Newako' – stand proudly by your partner – to create support in the community for male participation. Thirty-five female and four male outreach workers used role-playing and picture cards to promote discussion in the community about male involvement, and distributed educational materials targeted to men about pregnancy. Process data indicate that more males attended ANC with their partners over time, and preliminary analyses of survey data corroborate this finding.

CONCLUSION: The findings suggest that a community outreach component can be successful in getting men to accompany their pregnant partners to the ANC clinic. The implications of this finding and its relationship to other outcome variables, such as partner communication, violence and sexual behavior, will be discussed.

PARTNERS: Centre for Population Studies, University of Zimbabwe, Horizons Program

ADDITIONAL AUTHORS: Steve Pearson, Julie Pulerwitz, Ellen Weiss

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DOES MEN'S INVOLVEMENT IMPROVE WOMEN'S KNOWLEDGE AND CARE-SEEKING FOR OBSTETRIC DANGER SIGNS?

Susan E. Adamchak

LEARNING OBJECTIVES: Participants will learn an innovative, gender-sensitive intervention that can improve reproductive and maternal health knowledge among men and women, foster partner support and improve maternal outcomes in developing country contexts.

BACKGROUND: It is now accepted in Safe Motherhood programs that the 'three delays' faced by women with obstetric complications are responsible for maternal mortality and morbidity. An operations research project studying the effect of men's involvement in their pregnant partners' maternity care was carried out in Kwa Zulu-Natal, South Africa, and Delhi, India, under the auspices of the Population Council's Frontiers in Reproductive Health Program, in collaboration with local health systems.

METHODOLOGY AND RESULTS: Involvement included inviting men to join their partners in individual and group counseling during antenatal care and at six weeks postpartum. Counseling and other behavior change communication strategies were directed toward improving sexually transmitted infection- and HIV-protective practices, increasing family planning knowledge and postpartum use, improving breastfeeding practices, and recognition of and planning timely and appropriate care-seeking if experiencing a danger sign. Despite contextual differences, there was a high willingness of women to involve their partners in maternity care and decision-making, and men were interested in doing so. More than 90 percent of both women and men were willing to have couple counseling. Pre-intervention knowledge of danger signs in India was extremely low; fewer than 15 percent of pregnant women were able to name even one danger sign. South African women were more knowledgeable, but there was room for improvement: only about 50 percent named abnormal bleeding as a danger sign and fewer named any other sign. Men were also poorly informed.

CONCLUSION: Data are presented from women and men's postpartum surveys comparing intervention and control clients and partners' knowledge of danger signs and prevalence of care-seeking behavior.

PARTNERS: The Frontiers in Reproductive Health Program (Population Council, Family Health International, Tulane University), Employee State Insurance Corporation, Reproductive Health Research Unit, Department of Health, Kwa Zulu-Natal

ADDITIONAL AUTHORS: Leila Caleb Varkey, Anjana Das, Anurag Mishra, Mags Beksinska, Busi Kunene, Saiqa Mullick, Emma Ottolenghi

SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

New Approaches to Improving Sexual and Reproductive Health

IMPROVING COUPLE COMMUNICATIONS THROUGH AN INTEGRATED DEVELOPMENT PROGRAM

Laxmi M. Madras

LEARNING OBJECTIVES: Participants attending this session will be able to evaluate changes in couple communications related to participation in an integrated development program, as well as related changes in agricultural practices and gender equity.

BACKGROUND: The integrated development program in Karnataka State, India, focuses on working with marginalized populations in isolated rural areas of the state. Initiated in 1993, the program focus was on sustainable agriculture with an aim to increase production of food crops using the strategy of working with small farmer groups, usually 15-20 members, as a way to introduce innovation. While some of these groups included women, the vast majority of participants were men. However in 1998, with the introduction of the reproductive health component, which included the formation of women's savings and credit groups, the program underwent a dramatic change. Initially aided by the farmer groups, the number of women's groups quickly increased and their organizational capacities began to rival that of the more established groups. In order to better understand these changing dynamics and the program effects - both intended and unintended, an evaluation was undertaken using both participatory and survey methodologies. The evaluation design included a comparison group from a village where only sustainable agriculture activities were implemented. It was found that more couples in the integrated program reported discussing issues of family size and family planning use than did couples in the comparison village. Knowledge regarding improved agricultural practices was higher for women in the integrated program than in the agricultural alone program. There were also positive trends in indicators for women's status, such as decision-making, property ownership and protest against violence. Reproductive health service use, such as family planning and prenatal care, was much higher for the integrated program.

CONCLUSION: This study is an initial attempt to examine the outcomes of an integrated program, beyond the simple sectoral measurements. Although not an objective of the program, it was found that the program appeared to have positive effects on couple communication and key indicators of women's status.

PARTNERS: Bayalu Seeme Rural Development Society, Ministry of Health

ADDITIONAL AUTHORS: Catharine McKaig, Subhash Gumaste

SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

New Approaches to Improving Sexual and Reproductive Health

MEN: CATALYSTS FOR IMPROVED HEALTH STATUS OF SEX WORKERS

Lalita Shankar

LEARNING OBJECTIVES: Participants will explore initiatives for improved health status of vulnerable populations, such as sex workers, that involve men as agents of their own behavior change through nonthreatening facilitators.

BACKGROUND: With current HIV prevalence rates among truckers in India around 10 percent, effective interventions among truckers is critical to strengthen India's response to AIDS. The construction of the 'golden quadrilateral' highway project linking four strategic cities has accelerated the permeation of the epidemic from urban to rural areas. CARE/India's OK TATA (Orientation of Key Truckers Associates and Transporters on AIDS) Intervention Project operates from Raipur, the highly industrialized capital city of Chhattisgarh in the heart of India. Raipur links the eastern and western road corridors through the vital National Highway #6 where nearly 20,000 trucks transit daily. The project area overlaps with nearly 150 brothel-based and floating commercial sex workers. The traditional three-pronged approach of promoting safer sexual behavior, reducing sexually transmitted infection (STI) transmission and increasing condom usage has paved the way for an expanded response. Trained women peers from the sex workers community now focus on communicating with the truckers directly along the highway. By acknowledging the importance of male involvement in pivotal decision-making processes in behavior change, the women have sensitively placed their own concerns to encourage dialogue and commitment toward safer sex practices from the men.

CONCLUSION: The initiative of a shift of focus by the peers from the sex workers community on the highway directly to the clients (men) was implemented to enable the trucker to consider his complementary role as part of an empowering community that can contribute to reducing HIV transmission, rather than being seen as responsible for the spread of HIV. Drivers saw the women as nonthreatening facilitators to the behavior change process in discussing issues critical to their community, such as availability of condoms or nonprovision of basic amenities by the transport sector or spread of HIV from the urban to rural area. By encouraging drivers to contribute to averting the number of HIV infections, the misplaced suspicions of targeting them as a community is largely assuaged. Over 40 percent of the STI patients at the CARE mobile clinics were referrals by the women peers. Condom sales increased from nil in March 2002 to over 6,000 by August. For most women in India, sex is associated with a lack of control, abuse and resounding silence. In such a scenario, a marginalized sex workers community, the most vulnerable to HIV, has succeeded in protecting themselves, demonstrating a positive impact on their own health.

PARTNERS: Civil society and networks of Transporters Association and Barbers Association

ADDITIONAL AUTHORS: Y.P. Gupta, Satyajit Ghosh

LEARNING OBJECTIVES: Participants attending this session will be able to understand how verbal autopsies were used as a tool to understand sociocultural causes of maternal deaths and modify programmatic interventions for reducing it.

BACKGROUND: Rapid population growth in Indian cities as a result of economic opportunities has led to a considerable proportion of the population residing in slums. Women living here consistently fail to prioritize their health. Early marriage, frequent childbirths, high percentage of domiciliary deliveries and poor living conditions compromise their reproductive health status. CARE/India is implementing a project from 1999 in 143 urban slums of Allahabad, Uttar Pradesh addressing the high reproductive health-related morbidity and mortality through health education, formation of women's/men's health groups, strengthening of the existing health infrastructure and training of grassroots-level health functionaries. One of the major activities of the project is to conduct verbal autopsies of maternal deaths, using them as case studies for social audits leading to programmatic changes.

CONCLUSION: The number of maternal deaths was reduced in project slums from 17 in 1999 to six in 2002, although the number of home deliveries increased from 1,258 in 1999 to 2,309 in 2002. Local medical practitioners (qualified, unqualified) need to be sensitized to the four delays and misuse of oxytocic drugs. Verbal autopsies can be used as a tool to understand root causes of maternal mortality for making program-specific strategic changes.

PARTNER: Government of Uttar Pradesh

ADDITIONAL AUTHORS: YP Gupta, Manohar Shenoy, Gita Biswas

SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

Obstetric Outcomes among Slum Dwellers

PROGRAMMATIC IMPLICATIONS OF VERBAL AUTOPSIES

Loveleen Johri

LEARNING OBJECTIVES: Participants will be enlightened on the unfavorable social environment of teenage motherhood in the slums, and factors that most influence survival of their children.

BACKGROUND: The study objective was to assess and compare pregnancy and child health outcomes of teenage (aged less than 20 years) and adult (20-34 years of age) mothers.

METHODOLOGY AND RESULTS: Women whose age fall in the target group at the birth of their first child were selected out of the total 3,256 women in reproductive age group (15-49 years) and 1,934 adolescent girls (12-24 years of age) covered by the Nairobi Cross-sectional Slums Survey. The recall period for the history on the index pregnancy, delivery and child health outcome spanned from January 1997 to June 2000. The main comparison involved sociodemographic variables, events during pregnancy, obstetric outcome, child morbidity and mortality, and care provided during an illness episode. The study found that significantly higher proportions of teenage mothers and their partners had lower educational achievement compared with adult mothers and their partners. Teenage mothers tended to be poorer and less likely to have ever been married. The two groups of mothers were comparable in terms of the rate and timing of antenatal care visits, place of delivery, rate of operative deliveries, reported size of the baby, child vaccination status and reported morbidity and health-care practice during an illness episode. The index child was alive during the survey period for 89.4 percent of the teenage and 96.6 percent of the adult mothers (odds ration 3.36; 95% confidence interval 1.34-8.79). Child survival rates in the two groups of mothers were found to be quite similar after controlled analysis for the influence of socioeconomic factors.

CONCLUSION: Bad obstetric outcomes and child health malpractices are weakly dependent on maternal age. Most factors affecting child survival might be rooted in the poor socioeconomic background and achievements of teenage mothers.

SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

Obstetric Outcomes among Slum Dwellers

TEENAGE MOTHERS AND THEIR CHILDREN IN NAIROBI SLUMS: OBSTETRIC AND SOCIAL OUTCOMES

Negussie Taffa

SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

Optimal Birth Spacing

EFFECT OF BIRTH INTERVALS ON MORTALITY AND HEALTH

Shea Oscar Rutstein

LEARNING OBJECTIVES: Participants attending this session will be able to: 1) understand the optimal birth interval from a health standpoint; 2) learn the actual birth interval and preferred birth intervals lengths; and 3) understand the effects on mortality, health outcomes and population issues that occur when birth intervals are changed from actual to optimal and preferred.

BACKGROUND: The objective of this research was to: 1) determine the optimal birth interval from a mortality and health standpoint; 2) discover what lengths of birth intervals women have and prefer; and 3) evaluate the effects on mortality of changing from actual lengths of intervals to preferred and optimal lengths.

METHODOLOGY AND RESULTS: The effects of birth spacing on infant and child mortality have been examined previously, and the deleterious effects of too short an interval between births are widely known. The current study re-examines these effects utilizing demographic and health survey data for 20 less developed countries. The analyses of interval length and various mortality and health outcomes utilize multivariate analysis, controlling for a host of potentially confounding factors, including prior experience of child death and length of breastfeeding. The analyses reconfirmed that the length of time between births (and pregnancies) is a very important factor in the health of young children. Moreover, it is shown that for stillbirths, perinatal mortality and neonatal mortality and for size at birth, optimal birth intervals occur between 36 and 42 months when considering preceding birth intervals. For mortality at older ages and for chronic malnutrition, even longer intervals are better. These differences in optimality are attributed to differences between biological and sociobehavioral factors. The second and third aspects of the study examine the potential for averting child death by changing the distribution of actual birth intervals.

CONCLUSION: Birth (and pregnancy) intervals have important effects for the mortality of children and birth outcomes. Birth intervals of 36-47 months for infants and children under age 5 years, and 36-42 months for neonates and those in the perinatal period are preferable to birth intervals of 24-35 months in almost all cases.

ROUNDTABLES

SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

Optimal Birth Spacing

IMPACT OF THE INTERPREGNANCY INTERVAL ON PREGNANCY OUTCOMES

Agustin Conde-Agudelo

LEARNING OBJECTIVES: Participants will be able to know the effects of both short and long interpregnancy intervals on maternal/perinatal morbidity and mortality.

BACKGROUND: The objective was to determine the effects of interpregnancy intervals on maternal/perinatal morbidity and mortality in Latin America.

METHODOLOGY AND RESULTS: A retrospective cross-sectional study was performed with data from the perinatal information system database of the Latin American Center for Perinatology and Human Development in Montevideo, Uruguay, which has recorded pregnancies of Latin American women from 1985-2001. The study population was 1,080,650 parous women delivering singleton infants, whose previous pregnancy ended in live birth after 19 weeks gestation. Odds ratios (OR) were computed as measures of association between interpregnancy interval and adverse pregnancy outcomes considered. The estimates were adjusted for 16 confounding factors through multiple logistic regression analysis. The interpregnancy interval of 18-23 months had the lowest rates of adverse pregnancy outcomes. After controlling for major confounding factors, women with interpregnancy intervals of less than 5 months, compared with those conceiving at 18-23 months after a previous birth, had higher risks for maternal death (OR 2.54; 95% confidence interval (CI) 1.22-5.38), third trimester bleeding (OR 1.73; 95% CI 1.42-2.24), premature rupture of membranes (OR 1.72; 95% CI 1.53-1.93), puerperal endometritis (OR 1.33; 95% CI 1.22-1.45) and anemia (OR 1.30; 95% CI 1.18-1.43). Women conceiving after more than 59 months had increased risk of preeclampsia (OR 1.83; 95% CI 1.72-1.94) and eclampsia (OR 1.80; 95% CI 1.38-2.32). As compared with infants conceived 18-23 months after a live birth, infants conceived after less than 6 months had OR of 2.14 (95% CI 2.02-2.28) for low birth weight, OR 1.15 (95% CI 1.10-1.21) for very low birth weight, OR 2.31 (95% CI 2.20-2.43) for preterm delivery, OR 3.27 (95% CI 2.98-3.58) for very preterm delivery, OR 1.25 (95% CI 1.20-1.31) for small for gestational age, OR 2.40 (95% CI 2.14-2.69) for fetal death, and OR 2.02 (95% CI 1.48-2.63) for neonatal death. Moreover, infants conceived after 6-11 months and greater than 60 months had higher risks of adverse perinatal outcomes than those conceived 18-23 months after a previous live birth.

CONCLUSION: Interpregnancy intervals of less than 12 months and greater than 59 months are associated with increased risk of adverse pregnancy outcomes.

PARTNERS: Latin American Center for Perinatology and Human Development, Catalyst Consortium

ADDITIONAL AUTHOR: Jose M. Belizan

LEARNING OBJECTIVES: Participants will be able to: 1) describe the post-abortion care (PAC) model that is used in Peru; 2) explain how offering PAC on an outpatient basis can reduce costs and increase access; and 3) apply lessons learned from Peru to improve quality and accessibility in PAC programs in other developing countries.

BACKGROUND: Since 1997, the Ministry of Health (MOH) in Peru, with technical support from Pathfinder International and funding from DFID, has carried out the Post-Abortion Care Project in public health facilities. Beginning in 1997, the project was developed and piloted in 13 facilities. The project expanded its reach between 1998-2001 to include a total of 43 health facilities from Levels I, II, III and IV. The objectives of the project were to: 1) provide a more sensitive and caring approach to patients seeking treatment for an incomplete abortion; 2) increase the number of cases of incomplete abortion without complications that can be handled on an outpatient basis; 3) reduce the cost of PAC services; 4) improve the quality and accessibility of PAC services; and 5) include family planning (FP) services as a key element in PAC. In the past, PAC patients seeking treatment at MOH facilities underwent complete anesthesia and D&C followed by a 1- to 2-day stay in the hospital. The PAC model increased the quality of care by focusing heavily on counseling throughout the PAC process, the use of manual vacuum aspiration (MVA) and the provision of post-abortion FP. Health providers were also trained to provide PAC on an outpatient basis, thereby costs have been cut substantially and access to PAC services has increased. Between 1998 and 2001, 39,335 cases of incomplete abortion were treated in the public health facilities. In 2001, 14,586 PAC patients were treated; among these, 7,332 (50.72 percent) were treated with MVA and 7,254 with D&C. In the health facilities where the project had operated for four years, MVA was used to manage 62 percent of cases of incomplete abortion. Under the project, post-abortion contraceptive use doubled from 27 percent to 54 percent. Sixty percent of the facilities have established norms that incorporate PAC into outpatient services. When the MVA technique is used (cases with no complications), 85 percent of the patients can be dealt with on an outpatient basis.

CONCLUSION: The majority of facilities have shown significant improvement over the life of the project; however, the political will to carry out this program has remained crucial to any success. The use of MVA for the treatment of complicated abortions is increasing each year, while the use of D&C is diminishing progressively. However, the lack of national norms within the MOH for PAC is still a challenge, making it difficult to integrate PAC into FP services at a national level.

ADDITIONAL AUTHORS: Jhony Juárez, Elvisa Loayza

SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

Post-abortion Care

IMPROVING QUALITY AND ACCESSIBILITY OF POST-ABORTION CARE IN PERU

Miguel Gutierrez

LEARNING OBJECTIVES: Participants will be able to identify the role of private nurse-midwives in the Kenyan health-care system and assess their potential as providers of non-hospital-based post-abortion care (PAC) services on a national scale.

BACKGROUND: Complications from unsafe or incomplete abortion are a major cause of maternal mortality in Kenya and add tremendous strain on the overburdened public sector health-care system. With technical assistance from the PRIME II Project, 230 private sector nurse-midwives from 164 facilities have been trained in PAC since 1998 in three provinces. Training emphasizes a comprehensive approach to PAC services. In addition to providing treatment for potentially life-threatening complications, the nurse-midwives counsel clients about family planning and contraceptive options, provide or refer clients for methods to help clients prevent future unwanted pregnancies and practice birth spacing, and provide or refer for other reproductive health services.

METHODOLOGY AND RESULTS: Data from a USAID/Kenya evaluation on more than 1,600 clients served by PRIME-trained nurse-midwives for complications from unsafe or incomplete abortions revealed that 93 percent were successfully treated using manual vacuum aspiration (MVA) and 3 percent were managed without MVA. Only 4 percent had to be referred to higher-level facilities after arriving with advanced complications that could not be treated by the nurse-midwives. PRIME reported that 81 percent of PAC clients received counseling for family planning, with 56 percent leaving the facility with a contraceptive method or saying they would return to purchase one. In addition, clients received counseling for sexually transmitted infections/HIV prevention (74 percent), breast cancer (48 percent), cervical cancer (38 percent) and nutrition (50 percent).

CONCLUSION: Kenyan private nurse-midwives are capable of providing quality PAC services and handling a wide variety of complications and emergencies. The high percentages of PAC clients receiving family planning counseling and services reinforce the importance of linking MVA with family planning as a main prevention strategy to reduce unwanted pregnancies and unsafe abortion. The private sector status of the nurse-midwives and their accessibility to underserved populations in urban, peri-urban and rural areas throughout Kenya hold great promise for a national, financially sustainable base for primary-level PAC services.

PARTNERS: Kenya Ministry of Health, Nursing Council of Kenya, National Nurses Association of Kenya

ADDITIONAL AUTHORS: Maureen Corbett, Pauline Muhuhu, Florence Githiori

SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

Post-abortion Care

PRIVATE NURSE-MIDWIVES: AN IDEAL CADRE FOR COMMUNITY-LEVEL POST-ABORTION CARE IN KENYA

Richard Mason

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SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

Reducing Maternal Mortality and Morbidity

INITIATING PERINATAL CARE IN EGYPT

Tom Coles

LEARNING OBJECTIVES: Each participant will be able to identify a minimum of two key elements that contributed to the successful implementation of a perinatal care program in Egypt, and to determine if the perinatal care program development process could be adapted and applied to meet his/her program needs.

BACKGROUND: The National Maternal Mortality Study (NMMS): Egypt 2000 documented that mortality in infants of women who die from maternal causes has declined. In 50 percent of the cases of maternal death in 2000, the fetus or infant also died, whereas the figure for 1992-1993 was 57 percent. When maternal death occurred during delivery or postpartum, 34 percent of infants died at birth or soon after, compared to 43 percent in 1992-1993, suggesting that there may have been improvement in care of newborns. Historically, perinatal services did not exist in Egypt, nor did the perinatology specialty. Attempts in the mid-1999s to establish these services and specialty failed. It was not until obstetricians and neonatologist were trained together to first identify high-risk mothers and then work as a team to provide neonatal care did attitudes and behavior begin to change. In 2002, receptivity to providing perinatal services in Egypt was established.

CONCLUSION: It takes time to convert from departmentalized tunnel vision where roles and responsibilities are guarded to a multidisciplinary team approach to providing integrated maternal, fetal, neonatal and postpartum services. Teaming obstetric and neonatal faculty together to plan, implement and monitor integrated services was the turning point. The demonstrated reduction of maternal and neonatal mortality in Egypt reinforced the utility of this approach and opened the door to establishing perinatal services. This conversion was made easier by the numerous lessons learned, which were applied to developing: 1) a system for ambulatory perinatal care; 2) a system for inpatient perinatal care; 3) the concept of regionalized perinatal care; and 4) national guidelines for the provision of perinatal care.

PARTNERS: Healthy Mother/Healthy Child Project staff Ministry of Health and Population (MOHP), other MOHP representatives, university medical school and nursing school faculties in Egypt, George Washington University

ADDITIONAL AUTHORS: Lamia Mohsen, Ayman Mohandes

ROUNDTABLES

SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

Reducing Maternal Mortality and Morbidity

TRAINING FOR COMPETENCE: REDUCING MATERNAL MORTALITY IN EGYPT

Azza El-Husseiny

LEARNING OBJECTIVES: By the end of the session, each participant should be able to identify a minimum of two key elements that contributed to the successful implementation of the competency-based training (CBT) program development process in Egypt, and to determine if the seven-step CBT program development process could be adapted and applied to meet his/her training program needs.

BACKGROUND: In 1994, the CBT program development process was introduced to the Ministry of Health and Population (MOHP) in Egypt through the USAID-funded Child Survival Project. CBT activities have continued in Egypt through the Mothercare Project and currently under Healthy Mother/Healthy Child. CBT methodology is hands-on 'learning by doing.' The workshop or classroom setting is not adequate in and by itself to assure skill development in CBT; each participant's progress is continually measured against pre-established performance criteria as stated in the observable and measurable learning objectives. On-the-job training provided by a competent team of multidisciplinary trainers and clinical supervisors lowers risks to patients and providers. Recruited from the MOHP, university faculty and the private sector, these professional role models have placed more emphasis on provider attitudes and behaviors in addition to assuring skill mastery using a variety of job aids, while strengthening the skills of local level MOHP trainers/supervisors so a sustainable training support system can be institutionalized and sustained.

CONCLUSION: Ninety-two percent of maternal deaths in Upper Egypt are due to avoidable factors. It was originally thought delays in seeking care, delays in referral, lack of transportation and lack of essential drugs or access to blood transfusion were the primary contributing factors. In reality, health-care providers directly attributed to 47 percent of these maternal deaths due to substandard care. The staff capabilities and compliance with service standards had to be improved to effectively deal with the problem of avoidable deaths. The National Maternal Mortality Study: Egypt 2000 documented that maternal mortality has been reduced in Upper Egypt by 57 percent since the 1992-1993 survey. The training of competent service providers was a contributing factor to this reduction in mortality.

PARTNERS: Healthy Mother/Healthy Child Project Staff (MOHP), other MOHP representatives, university medical school and nursing school faculties, representatives from the private sector, USAID, Clark Atlanta University, John Snow, Inc.

ADDITIONAL AUTHORS: Tom Coles, Reginald Gipson

LEARNING OBJECTIVES: Participants will understand what Vietnamese youth want and expect from public sector reproductive health (RH) services.

BACKGROUND: In Viet Nam, approximately 30 percent of the population is between the ages of 10-24 years. Living in a society that is rapidly changing, traditional attitudes and values toward sex and sexuality are being questioned by youth, and practices that put youth at risk of unwanted pregnancy and sexually transmitted diseases are increasing. Service data indicate that the youth of Viet Nam do not frequent public sector facilities for family planning and RH counseling services. A 2000 situation analysis showed that youth are almost entirely absent from government maternal/child health and family planning services. Youth seem to avoid government services because they are not 'youth-friendly,' because they are worried about confidentiality and provider biases. Few alternatives exist to public sector services. Nationwide, there are only a few institutions offering RH services specifically to youth, and these are understandably small in scale. Private health-care options are growing but remain unorganized and unregulated. Recognizing that the public sector represents a critical resource to address youth's RH needs, Pathfinder International undertook qualitative research to better understand how public health services could be adapted to better address the concerns and needs of youth. Youth were involved in the design and conduct of the research.

METHODOLOGY AND RESULTS: Focus group discussions and in-depth interviews were conducted in four provinces where the Reproductive Health Program, a partnership of Pathfinder International, EngenderHealth, Ipas and the Ministry of Health work to improve the quality of existing RH services available in the public sector. Youth who use existing public and private sector services as well as non-users were queried to determine barriers and opportunities for the design of youth-friendly services. Interviews with providers revealed their level of readiness to serve youth. Pathfinder's youth-friendly services assessment tool was used. Preliminary findings from the research suggest that youth do not feel that services offered through the government's Maternal Child Health/Family Planning Network are welcoming for unmarried people. They fear judgment from staff, and consider staff attitudes to be the most important factor in providing quality services to youth.

CONCLUSION: The results of this study will be used to design innovative service delivery strategies to meet the needs of youth within public sector institutions. Study results are also expected to contribute to national policy discussions related to adolescent RH service delivery.

PARTNERS: Consultation for Investment in Health Promotion

ADDITIONAL AUTHORS: Hoang Tu Anh, Vu Song Ha, Ngo Van Huu

SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

Reproductive Health and Development

MAKING REPRODUCTIVE HEALTH SERVICES YOUTH-FRIENDLY IN VIET NAM'S PUBLIC SECTOR: LESSONS FROM FORMATIVE RESEARCH AND PROJECT DEVELOPMENT

Laura Wedeen

LEARNING OBJECTIVES: Participants will understand linked programs in the Vietnamese context, describe how reproductive health (RH) is integrated with other interventions, and analyze linked programs as a strategy to achieve the objectives of the International Conference on Population and Development (ICPD).

BACKGROUND: The 1994 ICPD in Cairo articulated a comprehensive definition of RH and highlighted the links between RH and women's economic and social empowerment. These links have been substantiated by various research findings. However, it is not clear whether linked intervention strategies are the best approach to address women's economic and RH needs. Sector-specific strategies are more common and often believed to be more efficient. A qualitative study of linked program approaches in Vietnam was performed. The study's purpose was to assess the extent to which RH has been integrated with other interventions, and the potential effectiveness of linked strategies for achieving ICPD objectives.

METHODOLOGY AND RESULTS: The study reviewed 16 linked programs in the north and south of Vietnam. In-depth interviews were conducted with national program officers. Two programs (one in the north and one in the south) were selected as case studies. Fifty-four in-depth interviews and four focus groups were conducted with beneficiaries and program officers at provincial, district and commune levels. Transcripts were coded and analyzed thematically using SPDATA, an ethnographic database program. It was found that linked strategies existed in Vietnamese health and social policies long before the ICPD, as an efficient approach to achieve health and development goals. Integration was commonly perceived as a way to save time and money and to implement activities that people found less attractive, such as health interventions. Integration of reproductive health with other interventions was not very common due to low advocacy, the complex nature of RH and the scarcity of resources. The focus of linked programs was still family planning. Gender and empowerment issues were often neglected or insufficiently addressed. A lack of male involvement reduced program impact. Lack of effort and resources for establishing coordination and collaboration were crucial factors in limiting the success of linked programs.

CONCLUSION: Integration was an efficient approach to meet the diverse needs of women within the context of scarce resources in Vietnam. However, effectiveness of linked programs is still limited due to lack of capacity, collaboration and coordination. Further efforts should be made to strengthen participatory approaches and increase male involvement. Advocacy is important to integrate RH with other interventions.

PARTNERS: Empowerment of Women Research Program, Population and Development International

ADDITIONAL AUTHORS: Tran Hung Minh, Bui Thanh Mai, Nguyen Minh Duc, Sidney Schuler, Diana Santillán

SOCSOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

Reproductive Health and Development

LINKING REPRODUCTIVE HEALTH AND DEVELOPMENT STRATEGIES IN VIETNAM

Hoang Tu Anh

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SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

Reproductive Health Challenges for Marginalized Populations

CHALLENGES OF TARGETING MIGRANT WORKERS IN RURAL INDIA

Jorge Mora

LEARNING OBJECTIVES: Participants will be able to identify major limitations of targeting migrant populations in rural and urban areas, determine the effectiveness of various strategies to provide reproductive health services, and understand how migration changes reproductive intentions.

BACKGROUND: India has the highest number of HIV-infected people of any other country outside Africa. At the end of 2001, India's national adult HIV prevalence was under 1 percent. However, there have been some reports of HIV prevalence higher than 2 percent among pregnant women and other population groups in various settings. In a pilot study conducted at the François-Xavier Bagnoud (FXB) Center for Infectious Diseases at the Bhagwan Mahavir Hospital in rural Rajasthan, a prevalence of 6 percent was found among 1,501 people screened for HIV. More than 90 percent of the cases were among migratory workers, and their level of knowledge about HIV/AIDS was very low. In a survey among 20,000 migrants and their families, it was found that just 3 percent knew all three forms of HIV transmission and more than 81 percent knew nothing about sexually transmitted diseases (STDs). Less than 4 percent reported using condoms to prevent STDs. Given the seriousness of the situation, FXB started an HIV/AIDS awareness program to target migrant populations in 180 villages. Since 2000, FXB's work with migrant workers has been mainly focused on collecting demographic and epidemiological information, training peer educators from the 180 villages about HIV/AIDS/STDs, conducting HIV awareness campaigns, training local health-care providers about HIV/AIDS, and linking rural and urban HIV prevention programs. However, the implementation of the HIV prevention programs has not been easy.

CONCLUSION: The migration of male peer educators who are already trained on HIV/AIDS from rural villages to the big cities, low acceptance of females as peer educators in rural villages, difficult identification of pockets of migrant workers in the big cities, low self-perception of risk for HIV among migrant workers, and absence of migrant workers in rural villages for most of the year have been some of the most relevant challenges that have been found in the HIV/AIDS awareness programs. To target migrant workers more effectively, it is necessary to link rural HIV awareness initiatives among migrant workers with urban initiatives, increase acceptance of females as peer educators, better identify routes of migration and risk factors, empower women on sexual issues and actively involve migrant workers in HIV/AIDS awareness campaigns to target their fellow workers in the big cities and along the routes of migration.

PARTNER: The Bill & Melinda Gates Foundation

ADDITIONAL AUTHORS: Rakhi Nair, Anil Purohit, Alejandro Haag

SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

Reproductive Health Challenges for Marginalized Populations

RESPONDING TO THE REPRODUCTIVE HEALTH NEEDS OF AFGHAN REFUGEES IN PAKISTAN

Ouahiba Sakani Afzal

LEARNING OBJECTIVES: Participants attending this session will be able to: identify components of the Minimum Initial Services Package (MISP) for reproductive health; understand the importance of implementing the MISP in emergency and post-emergency settings; and recognize the gaps remaining in improving access to quality reproductive health (RH) services to Afghan refugees in Pakistan.

BACKGROUND: The Women's Commission for Refugee Women and Children assessed the implementation of the MISP to understand the RH needs of the population and identify ways to improve the current situation.

METHODOLOGY AND RESULTS: The Women's Commission interviewed key individuals from UN agencies, the Pakistani government, and international and local NGOs working inside the camps or in urban or peri-urban areas in the North West Frontier, Baluchistan and Punjab provinces. Health facilities were also visited. Findings include: 1) Although the MISP is being implemented to varying degrees, substantial gaps remain. Many acting RH coordinators are not aware of the MISP. 2) Sexual violence against women and girls is not addressed, and few victims report. Many service providers are not trained to respond to gender-based violence and don't believe it is a problem. 3) A referral system for emergency obstetric care is in place, but transportation is often unavailable. Costs of services remain the main barrier to access for refugee women. 4) Some staff lack proper counseling training, equipment and supervision to adhere to universal precautions. Free condoms were available at nearly all health facilities visited, but safe sex behavior is not promoted. 5) Family planning services are available but the quality of services is lacking. Male and adolescent reproductive health is not prioritized.

CONCLUSION: MISP implementation must be advocated to improve the overall RH status of the Afghan refugee population in Pakistan. Areas for increased emphasis include: continued training for staff, procurement and distribution of supplies, emergency referral system, support for victims of sexual violence and a RH coordinator for each agency to plan for comprehensive RH activities.

PARTNER: United Nations Population Fund

ADDITIONAL AUTHORS: Sandra Krause, Julia Matthews

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SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

Strengthening the Delivery of Maternal and Reproductive Health Services

OBSTETRIC FISTULA: FINDINGS FROM NEEDS ASSESSMENTS IN NINE AFRICAN COUNTRIES

Joseph Ruminjo

LEARNING OBJECTIVES: Participants will be able to describe obstetric fistula, identify the scope of the problem in nine sub-Saharan African countries, and explain three innovative service delivery approaches to caring for women of all ages with fistula.

BACKGROUND: Obstetric fistula is a critically important and largely neglected issue in the field of reproductive health. WHO estimates that at least 2 million girls and women currently live with fistula, and an additional 50,000-100,000 are affected each year. For the vast majority of these girls and women, services to repair their conditions are out of reach for a number of reasons: their lack of knowledge that such a condition can be repaired; the distance they must travel to get to a facility that provides repairs; the low likelihood that if they can get to a facility, it actually offers fistula repairs in its portfolio of services; their inability to pay for the services if they are offered; and the backlog that facilities that do provide repairs currently have. To begin to understand how best to address possible strategic interventions, it is important to understand what facilities exist, how they operate and whether they are well positioned to improve and/or expand their services. This needs assessment provides a snapshot of how some clinical services for fistula clients have been organized.

METHODOLOGY AND RESULTS: The needs assessment was conducted by at least one clinical and one program staff member from EngenderHealth, during a series of site visits to 2-8 public sector and private sector hospitals in each country. Administrators and professional staff were interviewed, as well as fistula clients, whenever possible. The fistula clients interviewed included those who were awaiting repair surgery, immediately post-surgery and recovering in the post-op ward, significantly (greater than 6 months) post-surgery, or had carried a pregnancy post-surgery and delivered by cesarean section. A simple, nine-question survey instrument was used for each interview.

CONCLUSION: Obstetric fistula is a largely hidden but important problem in the nine countries that participated in this needs assessment. Specific community-based obstacles include marriages and (attempted) childbearing at a young age, a strong desire to give birth at home, lack of decision-making power by women about where, when and how to seek help during obstructed labor, and a lack of transportation options to get to a facility quickly. In addition, there are an inadequate number of facilities able to provide repairs due to a lack of basic supplies, an insufficient number of providers with the skills to provide repairs and a backlog of women, young and old, who need repairs. Despite these obstacles, innovative service delivery approaches were noted at both the community and the facility level, including creative ways to obtain necessary surgical supplies and providers with surgical skills, pioneering approaches to surgery when tissue was insufficient to do a repair in the traditional way, and inventive networking among providers to upgrade their skills.

PARTNERS: Ministries of Health and UNFPA country offices in Benin, Chad, Malawi, Mali, Mozambique, Niger, Nigeria, Uganda and Zambia, public and private sector hospitals in each country

ADDITIONAL AUTHORS: Erika Sinclair, Mary Nell Wegner

SOCIAL ENVIRONMENT AND HEALTH: REPRODUCTIVE AND MATERNAL HEALTH

Strengthening the Delivery of Maternal and Reproductive Health Services

STRENGTHENING THE DELIVERY OF MATERNAL AND REPRODUCTIVE HEALTH SERVICES IN RURAL POPULATIONS

Carlos Carrazana

LEARNING OBJECTIVES: By the end of the presentation, participants will understand how private sector interventions can strengthen community-based programs and the delivery of health services in rural populations.

BACKGROUND: Mujeres en Desarrollo Dominicana (MUDE), a nonprofit NGO, was created to respond to the needs of lower-income women in rural areas of the Dominican Republic. Many of these women are refugees from Haiti or belong to indigenous communities. Services provided by MUDE include microcredit, social services and a health program. MUDE leverages the strengths of its microcredit program to generate income that allows for the cross-subsidization of their health program. This goal is in part achieved through funding from the Summa Foundation. The health program is carried out through various interventions, including training, education, medical visits and the dissemination of information for the prevention of HIV/AIDS/sexually transmitted infections, cervical cancer, breast cancer and family planning. The interventions have been implemented in nearly 250 poor, marginalized, difficult-to-access communities in rural areas. The project has been executed through community organizations of rural women and skilled volunteer leaders residing in the communities, who together form a health network with ample experience and available working tools. Measurable health outcomes and development impact to date includes the establishment of a volunteer network comprised of 385 women, the creation of 25 sales units for the selling of contraceptives, and 21,326 cases referred to health-care providers for reproductive health services. The following results are to be achieved: 1) better access to quality reproductive health services for 80,000 poor women in rural communities; 2) increased availability of health products and services in areas of difficult access; and 3) increased institutional capacity to sustain the health program.

CONCLUSION: NGOs have an important role to play in the delivery of quality maternal and reproductive health services in rural areas. Financing and technical assistance can be used to promote the sustainability and growth of community-based interventions that contribute to positive public health outcomes in rural areas.

PARTNERS: MUDE, The Summa Foundation, USAID

ADDITIONAL AUTHOR: Rosa Rita Alvarez

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Global Health Council's
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The coordinated promotion and improvement of youth health and development is one of the most vital enterprises a global society can undertake to secure its future. Together, we have the means and expertise to do so. The Global Health Council's Annual International Conference for 2004 will serve as a vibrant forum for the exchange of ideas and lessons learned regarding health-related interventions initiated for youth, and increasingly by youth. We therefore invite health and development professionals, including providers, community organizers, program managers, policy-makers, researchers, advocates, as well as youth from around the world to submit abstracts in the following main issue areas for presentation at our 31st Annual Conference, June 1-4, 2004:

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- Sexual/reproductive behaviors: STD/HIV infection, early pregnancy
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- Violence: homicide, war and conflict, sexual violence
- Malnutrition/under-nutrition
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- Infectious disease

Health-related Developmental Issues for Youth

- Access to health information and services
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The Council also invites general submissions in its key health issue areas:

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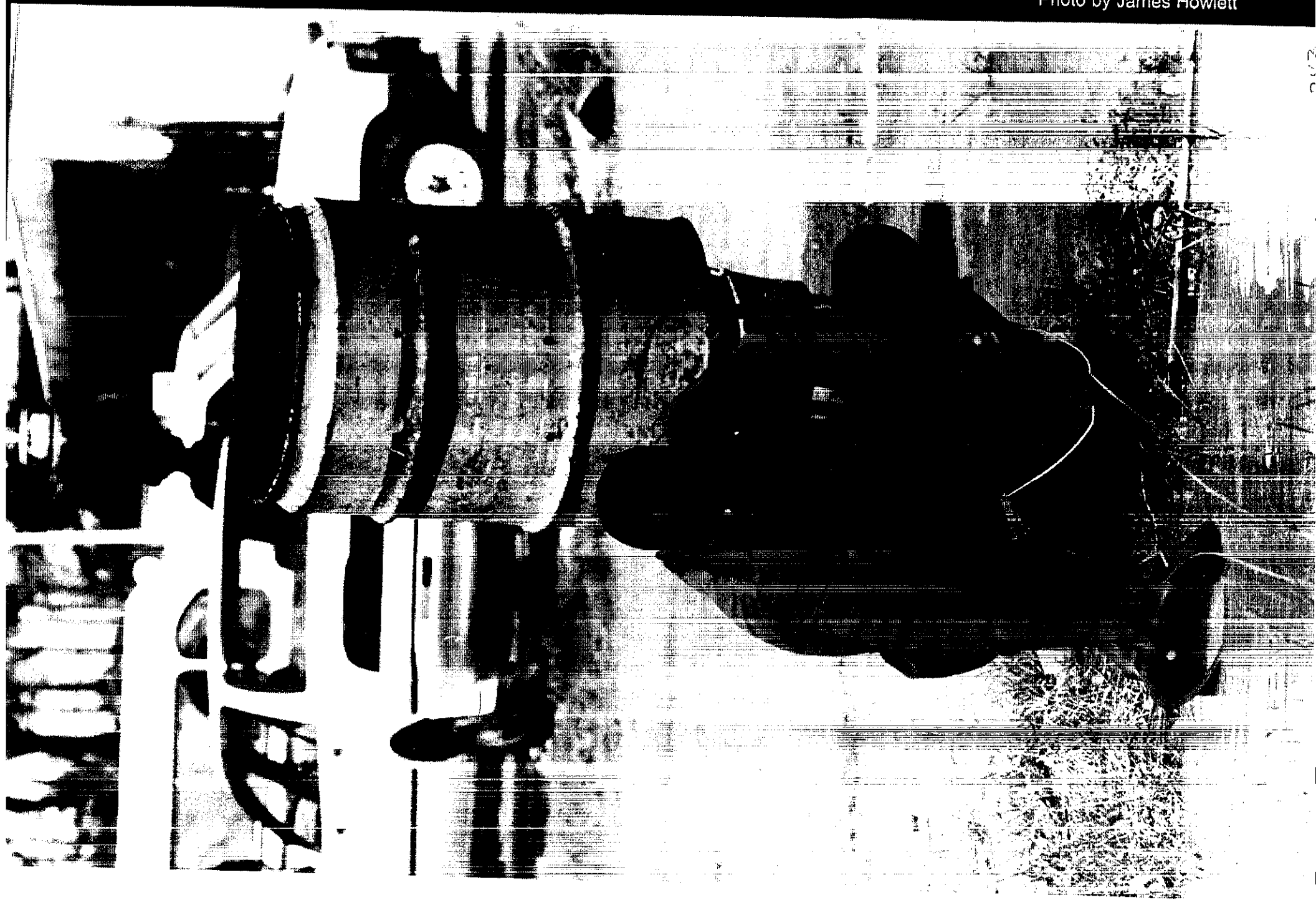

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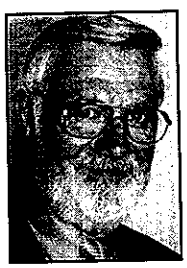
The Global Health Council would like to thank **Carol Emerling** and **Dr. James Strickler** for their years of guidance and valuable contributions to global health while serving as members of the Council's Board of Directors

Robert Black (2005) is the chair of the Department of International Health and the director of the Institute for International Programs at the Johns Hopkins University School of Hygiene and Public Health. Dr. Black has also served as consultant on the development of programs to control diarrheal diseases, acute respiratory infections and nutritional problems, and on the development of applied research and research capacity in developing countries. He received his AB from Cornell University, his MD from Hahnemann Medical College and his MPH from the University of California-Los Angeles.

Nils Daulaire (2004) is the president and CEO of the Global Health Council. Prior to assuming this position, Dr. Daulaire was the senior health advisor at USAID. Earlier, he worked for 15 years in primary health programs in Asia, Africa and Latin America, and carried out field research on child survival. Dr. Daulaire is board certified in preventive medicine. He received his BA at Harvard College, his MD from Harvard Medical School, and his MPH from Johns Hopkins University.



William Foege (2005) is the chair of the Global Health Council Board of Directors, a fellow at the Bill & Melinda Gates Foundation and a professor emeritus, Department of International Health, Rollins School of Public Health, Emory University. He is an epidemiologist who worked in the successful campaign to eradicate smallpox in the 1970s. In 1984, several colleagues and he created the Task Force for Child Survival, a working group for the World Health Organization, UNICEF, the World Bank, UNDP and the Rockefeller Foundation. Dr. Foege has also served as the executive director of The Carter Center. He received his BA from Pacific Lutheran University, his MD from the University of Washington Medical School and his MPH from Harvard University.

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Joel Lamstein (2005) is founder and president of John Snow, Inc., an international public health consulting group, and also serves as president of World Education. Mr. Lamstein is on the faculty of the Harvard School of Public Health and teaches organizational strategy, non-profit management, international development and strategic management. He received his BS in math and physics from the University of Michigan, and his SM from the Massachusetts Institute of Technology, Sloan School of Management.

Afaf Meleis (2005) is an internationally educated nurse and medical sociologist. Dr. Meleis has had an extensive academic and administrative career. In January 2002, she became the Margaret Bond Smith Dean of Nursing at the University of Pennsylvania School of Nursing. Dr. Meleis has been a Rockefeller Scholar, a Fellow of the American Academy of Nursing and a Kellogg International Fellow. Trained as a nurse in Cairo, she received her PhD in medical and social psychology from the University of California, Los Angeles.

* Term-end in parenthesis.

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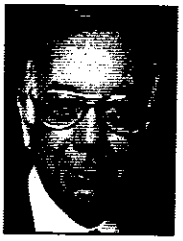
2003-2004 Board of Directors

Joe Peterson (2004) is president and chief executive officer of On Assignment, Inc. Dr. Peterson began his business career as medical director and ultimately COO of World Access, Inc., a subsidiary of Blue Cross & Blue Shield of the National Capital Area. Dr. Peterson is a board-certified emergency physician, and practiced his specialty for 10 years in the emergency department of the George Washington University Hospital in Washington, D.C., where he was an associate professor of emergency medicine and a fellow of the American Board of Emergency Medicine. He received his BA and MD from the Inteflex Accelerated Program at the University of Michigan Medical School.

Jan Piercy (2005) served from 1994 to 2001 as the U.S. executive director to the World Bank. She also serves as a commissioner of the White House Fellows Program and on the board of the Lewis T. Preston Fund for the Education of Girls. She is currently an advisor to Shorebank Corporation in Chicago, a company designed to promote economic development in disinvested urban and rural areas. Educated at Wellesley College, the Woodrow Wilson School at Princeton and the Senior Management Training Program at Stanford University, Ms. Piercy's efforts focus on promoting economic development, women's broader participation in public affairs and democracy building.

Barbara Pillsbury (2004) is the co-founder and director of Shared Lessons in Reproductive Health with the Pacific Institute for Women's Health. She is also the vice president and a consulting anthropologist at International Health and Development Associates. Dr. Pillsbury is a medical anthropologist specializing in program design and evaluation, and in reproductive health and women's issues in developing countries. She received her BS from the University of Minnesota, her MA from the Columbia University Teachers College, and her PhD in cultural anthropology from Columbia University.



Paul Rogers (2003) served for 24 years in the U.S. House of Representatives from the 11th District of Florida. Of those 24 years, he spent eight years as the chairman of the House Subcommittee on Health and the Environment and became known as "Mr. Health" in Congress. Mr. Rogers currently is a partner in the law firm of Hogan & Hartson in Washington, D.C. He received his law degree from the University of Florida in 1948, after serving with the Army in Europe for four years during World War II.

The Honorable **Louis W. Sullivan** (2004) is president of the Morehouse School of Medicine. Dr. Sullivan previously served as secretary of the U.S. Department of Health and Human Services, where he managed the federal agency responsible for the major health, welfare, food and drug safety, medical research and income security programs serving the American people. The recipient of more than 50 honorary degrees, Dr. Sullivan also serves on the boards of numerous organizations and corporations. He received his undergraduate degree from Morehouse College and his medical degree from the Boston University School of Medicine.

Board Members Elect

Rajat Kumar Gupta is the managing director of McKinsey & Company worldwide. Since joining the firm in 1973, Gupta has directed a number of projects aimed at helping companies develop new product/market strategies and reorganize for improved effectiveness and operations capabilities. He has a broad range of consulting experience with a variety of industries, including telecommunications, energy, and consumer goods. Gupta is Chairman of the Board of the Indian School of Business, and is associated with many other professional and business affiliations, including: Private Sector Representative to the Board of the Global Fund for Aids, Malaria, and Tuberculosis; Chairman of the Board of Associates of the Harvard Business School; and Dean's Advisory Council, Massachusetts Institute of Technology Sloan School of Management.

Philippa Lawson has more than 15 years' experience in HIV/AIDS-related prevention, support and care. She is currently a senior HIV/AIDS specialist with Futures Group, and provides HIV technical expertise to numerous Futures Group projects. She is developing and acting as the country manager for POLICY Project initiatives in Honduras. Since 1987, Ms. Lawson founded and directed numerous US/domestic and international HIV prevention and support related groups, projects and organizations, especially working with women, HIV-positive people, injection drug users, sex workers, prisoners, drug users and their families

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