

Long-Acting and Permanent Methods Community of Practice Launch

Highlights of an Experts' Consultation



Washington, D.C.
June 23, 2009

LA/PM Haikus

***LA and PMs;
Effective, convenient, safe;
One act; you decide.***

***Venue for colleagues;
LA PM CoP;
Join, contribute, learn.***

by

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- [Bill and Melinda Gates Foundation – FP/RH Strategy Overview](#)
- [Jadelle® Levonorgestrel Rod Implants: A Summary of Scientific Data and Lessons Learned from Programmatic Experience](#)
- [Long-acting and permanent methods: MSI's Global Impact](#)
- [Repositioning in Action E-Bulletin – June 2009: Sino-Implant \(II\) – A Dramatically Less Expensive Implant Option](#)



I. Purpose of the LA/PM Community of Practice and Meeting Objectives

The Long-Acting and Permanent Methods Community of Practice (LA/PM CoP) has been established to focus attention and energy on making the underutilized long-acting (IUDs and implants) and permanent (male and female sterilization) methods of contraception more widely available to meet the needs of individuals and couples worldwide, and to enable governments to achieve their national health and development goals. LA/PMs are appropriate for various groups (postpartum and postabortion clients, youth, and men) and can be used both for spacing and limiting births, as well as for delaying first births. The aim is to promote method choice, not particular methods.

A CoP is a group of people who share a concern or passion about a particular topic. It offers opportunities to engage a diverse group of professionals in collective learning and in sharing knowledge, solving problems, and establishing new ways of doing things. Direct, ongoing engagement of stakeholders makes a CoP different from other online professional communities.¹

The objectives of this LA/PM CoP launch meeting were to:

- 1) Share the latest global data on the status of LA/PMs
- 2) Exchange information about participating organizations' respective experience with LA/PMs, with a spotlight on implant experiences, planned implant activities, and programmatic issues
- 3) Clarify what a CoP is, explain the purpose of the LA/PM CoP, and generate interest and engagement from invited organizations
- 4) Identify and discuss potential future LA/PM CoP activities and products

Approximately 80 participants from 27 organizations in the nonprofit, government, and private sectors attended the launch.

These summary meeting highlights attempt to capture the key messages delivered by the meeting's presenters, who included distinguished representatives from the donor and cooperating agency communities. A synthesis of their presentations from the day's [agenda](#) is included herein. Links to speaking notes, handouts, and PowerPoint presentations (when available) are embedded for community members to learn more. Also, each summary of presentations is followed by a brief synthesis of the ensuing plenary discussions (but with no direct attributions).

¹ See [What Is a Community of Practice?](#) LA/PM CoP Brief No. 1, available from the LA/PM CoP Library on the IBP Knowledge Gateway.

II. What Is a Community of Practice?



Carolyn Curtis, AOTR/RESPOND, USAID Office of Population and Reproductive Health/Service Delivery Improvement, [welcomed](#) the participants and explained that LA/PMs are a technical priority within USAID and that the RESPOND Project, a USAID-funded global award, focuses on providing leadership to expand access to LA/PMs. RESPOND is taking the lead to bring together this CoP. This launch meeting serves as a catalyst to get the community engaged and moving forward.

A CoP is “a group of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis.” CoPs are formed by people who engage in a process of collective learning and knowledge-sharing in an area of mutual endeavor, to exchange information, solve problems, and develop new ways of doing. In the field of family planning (FP), it can be clinicians learning about a new surgical technique, or program and evaluation staff exploring a new implementation model. The Implementing Best Practices (IBP) Initiative or the membership of the Contraceptive Security Working Group each comprise a CoP. Etienne Wenger, an educational theorist and practitioner well-known for his work on CoPs, argues that a CoP has three key characteristics:

- A. The *domain*: A CoP is defined by the fact that its members share a domain of interest (e.g., a particular topic area or set of processes). Our domain is LA/PMs.
- B. The *community*: A CoP’s community consists of the people (and the organizations) who pursue involvement with the domain of interest, by engaging in joint activities and discussions, helping each other, and sharing information and expertise. This community engagement is a key aspect of a CoP.
- C. The *practice*: However, even a shared domain of interest and a community of like-minded people do not fully define a CoP. A CoP also must consist of members who have a shared repertoire of resources: practitioners relating their experiences, describing their tools, and explaining how they address recurring problems.

The combination of these three elements constitutes a CoP, and it is by developing these three elements in parallel that such a community is cultivated.



III. LA/PMs in Perspective: Current Status, Opportunities, and Challenges

Lynn Bakamjian (RESPOND Project) set the stage for the meeting with an [overview](#) of the status of LA/PMs, focusing on selected countries in Africa. FP has lost momentum in many countries in recent years, and LA/PMs have lagged even farther behind than short-acting methods. Countries now face a daunting FP challenge. While contraceptive prevalence has stalled, populations have continued to grow, increasing the unmet need to delay, space, and limit births and widening the gap between contraceptive prevalence and national goals. LA/PMs could significantly contribute to fulfilling this unmet need and to enabling countries to meet their population, health, and development goals. Ensuring access to LA/PMs as part of the method mix is vital to address the dissonance between women's expressed reproductive intentions and their method use.

LA/PMs pose particular programmatic challenges. Relative to short-acting methods, they are more difficult to provide, requiring more infrastructure and skilled providers. They also involve higher up-front costs and have unique commodity and equipment requirements. Managing human resource constraints may be the biggest challenge. Issues we need to better understand include the following:

- What are the most effective ways to incorporate **accurate information and messages** about LA/PMs into behavior change communication approaches?
- How do we address **commodity needs**, including planning for implant scale-up?
- How do we manage **human resource constraints** through task-shifting and training?
- How can we explore different **service delivery approaches** to expand access and scale-up?
- How do we make the case for increased **commitment and support** for LA/PM services?

Plenary Discussion

Options for increasing access to LA/PMs include task-shifting (or task-sharing) to expand the cadres of service providers, introducing the new, lower-priced implant (Sino-Implant [II]), and providing FP in the postpartum period. It was also noted the important role that men can play and the need to make vasectomy more available.

IV. Donor Perspectives and Program Priorities in LA/PMs



Scott Radloff, Director of USAID's Office of Population and Reproductive Health

USAID promotes the availability of a range of contraceptive options to maximize choice and use. Growth in the use of LA/PMs is one measure of a successful FP program. Looking beyond rates of contraceptive use, other measures include the percentage of the demand that is satisfied, both overall and among the underserved (including the poor and youth). Another message is the need to look at whether access to LA/PMs is adequate—a rough measure of which is how well method mix matches reproductive intentions. One example mentioned is Kenya, where data show that more than half of demand for FP is for limiting, but that LA/PMs represent less than 20% of contraceptive use. Improved access to LA/PMs will require improvements in human resources, contraceptive security, communications, and research and evaluation. We need to monitor the method mix and ensure adequate supplies of commodities and human resources. From a historical perspective, USAID has supported LA/PMs through the development of contraceptives and through epidemiologic research to increase understanding of LA/PM use, including IUDs for HIV-positive women, for example. LA/PMs are one of six technical priorities for the USAID Office of Global Health. In the Africa region, increasing access to and use of LA/PMs is a priority, second to contraceptive security.

The political environment for FP has changed dramatically under the Obama Administration, presenting an unmatched level of commitment, support, and overall favorable climate. Funding levels have doubled from FY08 to FY09, with significant increases expected in FY10. Noting that “these opportunities don’t arise every day,” Scott Radloff called upon the community to make a difference and for partners to work together to “get it right.”

Türkiz Gökgöl, Director of International Programs, The Susan Thompson Buffett Foundation

Despite the fact that private foundations are suffering the impact of the economic crisis, the Susan Thompson Buffett Foundation remains committed to FP and to comprehensive abortion care. The majority of projects that it funds have LA/PM-related objectives. Method choice is determined less by the donor than by the service provider, who ultimately decides what methods to offer based on availability (which relates to the logistics and distribution system), personal preference, and time constraints. The Buffett Foundation is interested in monitoring method use and discontinuation. They want to ensure that long-acting methods are available—particularly in settings where the supply chain for short-acting methods is unreliable and in cultures in which women do not typically keep track of the calendar (which is necessary for resupply methods). It was noted that IUDs have not received the attention they deserve, despite the fact that they are inexpensive, effective, safe, and widely acceptable. In this new political environment, postabortion contraception should be a higher priority.

Monica Kerrigan, Senior Program Officer, Reproductive Health, The Bill and Melinda Gates Foundation

Some of the Gates Foundation's first grants were made in the area of FP and reproductive health (RH). The Gates Foundation works to ensure that its investments reach the most vulnerable populations—poor women, men, and young people. The vision of the Gates Foundation strategy is to work with host country governments, donors, foundations, nongovernmental organizations, and implementing partners to revitalize FP globally for improving the health of mothers and children. The Gates Foundation's strategy rests upon the core principles of voluntary FP, quality products and services, and informed choice. The foundation has four FP/RH priority initiatives:

1. Global Advocacy to Revitalize FP and increased coordination to maximize impact
2. Country Action – Urban RH Initiative (serving the urban poor, including a proof of concept to test and validate that the contraceptive prevalence rate can be increased by integrating FP into maternal, newborn, and child health services, postabortion care, and HIV services).
3. Contraceptive Technology (covers both adaptive technologies such as Sino-Implant [II] and Depo-Provera [DMPA SQ] and new technologies). In regard to LA/PMs, the Gates Foundation's focus is affordable implants. Their geographic priorities are Africa and South Asia. It was also emphasized that one key reason for the foundation's interest in the Family Health International Sino-Implant II grant was their focus on “quality, quality, quality.”
4. Learning Agenda (related to examining new areas of RH, including delay of the first birth in Sub-Saharan Africa and South Asia and FP-HIV integration)

[Handout](#) from the Bill and Melinda Gates Foundation

Plenary Discussion

Supporting IUDs:

Though the IUD is the most cost-effective method in terms of couple-years of contraceptive protection provided, there is a long way to go to get this method into the method mix in many countries. IUDs hold a respectable place in programs supported by Population Services International (PSI), Marie Stopes International (MSI), and DKT. Their experience demonstrates the importance of addressing providers' misconceptions in order to increase their comfort with this method. PSI has found that increased use of IUDs can be achieved with little additional work. We should be careful not to lose focus on IUDs with the growing interest in implants. IUDs offer protection for a considerably longer period of time than implants; for some clients, the IUD can be practically as effective as tubal ligation. IUDs may be more acceptable in some contexts than implants, and it is important to be aware of informed method preferences. MSI's experience demonstrates the promise of increasing provision and use of IUDs through private-sector franchising. They have focused such initiatives on health providers who have not had a chance to be trained on IUD counseling and services and have found that such providers tend to receive training enthusiastically.

Improving service capacity, access, and quality:

- **Training**, both in-service and preservice, is critical for capacity development. Preservice training does not get as much attention as in-service training; this would be an important topic of discussion for our CoP. For preservice training, it is important to gain government support, to ensure that those who successfully complete the training are certified and ready to provide services. However, training itself is not enough to develop provider competence and comfort in providing LA/PMs. Follow-up should be built into all training programs; a year of “hand-holding” following training may be needed for some trainees before they can become fully effective providers. High staff-turnover rates pose a big challenge to service capacity and access. We need to make sure that the providers we train are going to stay in the system for some time, especially if we count on them to serve as a link in the referral network.
- **Task-shifting** to expand the cadre of LA/PM service providers expands service capacity and access. We should think about “**task-sharing**,” however, not just shifting, as we want those who currently supply services to continue to do so. We also need to provide effective **referral** for LA/PMs where these are not immediately available.
- **Quality assurance:** Pharmaceutical companies take responsibility for the quality of their products. Donors ensure the quality of services they support by training service providers, ensuring an enabling environment that supports service providers, and monitoring program activities using a number of quality indicators. Consistent technical support is needed to ensure ongoing program quality despite shifting priorities and relatively short program cycles.

Increasing demand for services:

There was agreement that robust, coordinated demand- and supply-side initiatives are needed to ensure that the capacity that is built is utilized. Given the high levels of unmet need for FP and for LA/PMs, we may not need to create demand so much as fulfill the existing but unsatisfied demand for LA/PM services. It was mentioned that we should consider changing our terminology and talk about “demand crystallization” instead of “demand creation.” It was also mentioned that resources should be directed toward making quality services available and toward satisfying demand rather than creating demand. All activities to inform women and men about the services available for their use should be considered a part of “demand satisfaction.” We have to get messages not just to providers but also to communities and potential clients. The evaluation of the Willows Foundation’s model [which integrates community based services with innovative ways to reach out to underserved populations], confirmed a significant behavior change regarding the increased use of existing FP services and the continuation of method use among women, was recommended.

Partnering to maximize impact:

Partnering at several levels offers opportunities to expand LA/PM access and use. The current political environment allows USAID to partner with more donors (e.g., the United Nations Population Fund) than was previously possible. Donors support successful partnerships among technical assistance and implementing partners from developing countries and the United States (e.g., the Buffett Foundation supports a linkage between the University of Michigan and faculty in Ghana for training, as well as a fellowship program with the American College of Nurse-Midwives). Public-private partnerships at the country level expand resources and program reach.



V. Featured Method: Hormonal Implants

Technical Update: *Jeff Spieler, Senior Technical Advisor for Science and Technology, USAID/Global Health Bureau/Office of Population and Reproductive Health.*

An effective contraceptive supply and logistics system is critical for successful FP programs in general, and for LA/PMs—including implants—in particular. (“No provider, no program; no product, no program.”) LA/PMs are highly effective, long-lasting, and cost-effective; they are suitable for different client groups and reproductive intentions, and they have high continuation rates.

Implants afford 3–5 years of contraceptive protection (Implanon: 3+; Sino-Implant [II]: 4+; Jadelle: 5), while permanent methods provide contraceptive protection for the remainder of the client’s fertile years (vasectomy is effective by three months after the procedure) and the IUD provides either 12 years or five years of protection (for the copper IUD and hormonal IUD, respectively). Over time, long-acting methods are more cost-effective than temporary methods, which require continuous resupply. Implants have a high up-front cost, but at five years of use, Jadelle and Norplant have only a slightly higher total cost than short-acting methods. (The IUD has the lowest up-front cost and remains the most cost-effective method of all.)

Key strategies for establishing and scaling up quality implant services include ensuring both adequate numbers of competent providers and a steady and increasing supply of implants; informing clients about the timing of removal (especially in settings where several varieties of implants with different duration of use are available); and ensuring that they have reliable access to removal services.

Implants Toolkit:

Ruwaida Salem, Senior Technical Writer, Johns Hopkins Bloomberg School of Public Health, Knowledge for Health (K4Health) Project.

An implants toolkit is under development and is being modeled after the IUD toolkit, which is an interagency, online product that was being hosted by the INFO Project at Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (JHU/CCP). The implants toolkit, which will be a priority activity of the LA/PM CoP, will be an “expert-filtered” electronic resource maintained and hosted on the K4Health web portal. The primary audiences are program managers, health care providers, policy makers, trainers, and information officers. EngenderHealth, Family Health International, and JHU/CCP are the initiating partners, and other cooperating agencies and technical experts will be invited to contribute to the development of this resource. The toolkit is being organized into “tabs” by topic headings. All information posted on the site will be vetted by experts, ensuring the quality of the content. During the construction phase, to facilitate the selection process, collaborators will be able to comment on the materials. The aim is for the toolkit to be live online by the end of 2009.

Plenary Discussion

Service costs:

All variables need to be factored in. Besides commodity and equipment costs, it is important to consider training costs, retention rates of providers, etc. Another necessary consideration is the cost(s) to the client (i.e., transportation to the clinic, lost wages, cost of unintended pregnancy, etc.).

Implants Toolkit:

A number of formats (including interactive applications, like a webinar) are being considered for inclusion in the implants toolkit at some point in the future. The larger community will be invited to test the alpha version of the toolkit later this year and to contribute to it by recommending, reviewing, and developing materials to include. The toolkit manager (i.e., a person from the working group selected to coordinate development of the overall toolkit) will work with the collaborating partners to review suggested materials and to vet those selected. USAID will be the arbiter in the case of any dispute regarding proposed documents. Working groups will move forward immediately to share information and identify materials to include. Tab managers will be identified for the key topics and will be responsible for developing or coordinating development of any new content for their respective toolkit tabs.

VI. Recent and Current Program Experience with Implants



Jadelle Levonorgestrel Rod Implants: Profile and Lessons, John W. Townsend, Director, Reproductive Health Program, Population Council.

While implants have multiple advantages that make them attractive to some clients, they also have some disadvantages: They offer no protection against STIs, including HIV; they are provider-dependent, requiring counseling and a skilled provider for both insertion and removal; and their up-front costs may be high.

The drug development process generally takes 10–15 years to go from an idea to a product, plus another 10–15 years to get the product rolled out and into use. For Norplant and Jadelle, product development took 30 years. The Population Council supported this process, in collaboration with several other partners. The following lessons can be drawn from preintroductory experiences in 30 countries:

- Program assessment should precede the introduction of the new product/method, to ensure that the context and human resources issues are understood.
- Introduction of a new implant should expand method choice and focus on ethically meeting women's needs.
- Participation of stakeholders is key to acceptance.
- Counseling and accurate information are critical for clients, providers, and the community.
- Providers must be trained in insertion and removal, as well as management of side effects.

- Logistics and assurance of a steady supply are critical.
- Supervision and evaluation are needed to ensure quality of care.
- Women must have access to removal on demand or when the approved duration of use is reached.

The procurement of implants has grown enormously since 2004. Implants are approved in more than 60 countries, including the United States. The World Health Organization's prequalification for Jadelle is currently pending. The price to clients will depend on procurement costs and client charges and subsidies. This presentation was based on the monograph [Jadelle® Levonorgestrel Rod Implants: A Summary of Scientific Data and Lessons Learned from Programmatic Experience.](#)

[Marie Stopes International's LAPM Experience](#), Heidi Quinn, Regional Technical Advisor, MSI.

MSI and its partners support the full range of LA/PM services. MSI employs a “one-stop shop” service model that offers short- and long-acting FP methods (including permanent methods), HIV screening, and lab services, as well as some general health services. They support both static and mobile services. MSI uses a franchise model, partnering with clinics that are not connected to the system or that are not receiving adequate levels of support.

MSI's experience has identified several challenges for implant services:

- | | |
|--------------------------------|--------------------------------|
| • Availability/registration | • Provider training and skills |
| • Quality | • Data collection |
| • Price | • Research |
| • Balancing demand with supply | • Bias for implants |

[Handout](#) from MSI

[Increasing Access through Low-Cost Implants](#), David Asante, Research Associate, Family Health International (FHI).

The low-cost Sino-Implant (II) and Zarin® are the same product, which will be marketed under different names in different countries. A recent FHI study of 21 sites found that implants can be provided at an affordable cost and that access to removal was not an issue. Zarin® is particularly attractive because it costs less than any other method except for the IUD (in terms of couple-years of protection) and is about half the cost of other implants.

Zarin® is currently registered in four countries (China, Indonesia, Kenya, and Sierra Leone). The Gates Foundation is supporting registration in at least 14 countries. Registration is under review in eight countries and is in progress in nine others. More than 7 million implants have been distributed to date. FHI has a six-year exclusive distribution agreement that affords FHI a price ceiling for public and nongovernmental programs. Adding Zarin® to the range of available implants can bring about significant program savings. FHI wants to collaborate with service delivery partners to develop introduction and scale-up strategies that are tailored to specific countries' needs and circumstances.

Link to [Repositioning in Action E-Bulletin – June 2009: Sino-Implant \(II\) – A Dramatically Less Expensive Implant Option](#)

Social Marketing to Increase Access to and Demand for Implants, Brad Lucas, Global Director, Reproductive Health, Population Services International (PSI).

Two supply-side strategies have been shown to be effective for increasing access to implant services:

- Private-sector social franchising networks, which can build competence and confidence and can provide whatever is needed to make implants available
- Public-sector partnerships, which can work with ministries of health to identify individuals responsible for providing LA/PMs and then generate demand for services and conduct outreach to provide long-acting methods in the communities

Before trying to stimulate client demand, we need to ensure that providers are willing to provide long-acting methods. We can then employ any of the following proven demand-creation strategies, such as:

- Event days
- Interpersonal communications (IPC) agents
- RH hotlines
- Mobile video units
- Mass media

PSI's experience has shown that there is a huge latent demand for implants; that nurses can provide high-quality implant services; and that users of injectables and oral contraceptives are "trading up" to implants and IUDs in significant numbers. The key challenges for implant programs are cost, supply, and removal.

Plenary Discussion

- **Mobile services:** This is a key strategy for increasing access. MSI has found it particularly effective for tubal ligation.
- **Dedicated resources:** Dedicated health providers and facilities may be a key to successful implant programs, though this needs to be balanced with sustainability.
- **Supply:** In countries where the commodity supply has been unreliable (e.g., Tanzania), MSI has had partnerships with pharmaceutical companies that have allowed them to recover commodity costs to provide needed services. Sino-Implant (II) may provide another opportunity to recover costs and ensure supply.
- **Quality assurance:** Quality can be a concern in private, franchised services (where monitoring may be inadequate) and in mobile services (which afford little or no access to providers for follow-up). While these service models offer great promise, cautious approaches are called for to ensure service quality and follow-up.
- **Need for other methods:** The evidence shows a latent need for all LA/PMs, not just for implants.



VII. Moving Forward as a Community of Practice

(1) The CoP's agenda for FY 09–10

Several priorities have already been identified:

- Produce the implants toolkit; populate it and “go live” by December 2009. (*Members of the CoP were invited to sign up for thematic working groups.*)
- Form a research working group to identify and prioritize research topics to advance our collective efforts. (*Members of the CoP were invited to join.*)
- Establish and maintain an electronic community web page on the IBP Knowledge Gateway.
- Conduct another technical consultation to explore in-depth priority issues related to one or more LA/PMs.
- Explore opportunities for an online moderated discussion on a theme to be determined.

(2) Recommendations for additional topics to address in future

- An in-depth look at country-specific approaches, using case studies (This should also prove to be another way to engage the field.)
- Tubal ligation
- More input from providers, champions, and nonchampions
- More robust data on women's needs regarding contraceptive needs (i.e., that different methods might be appropriate for different ages and parity, etc.)
- Rational approaches to staffing for LA/PMs (such as looking at the role of community health aids and clinical providers; examining the distribution of work at busy organizations; or determining if a dedicated provider is the way to go)
- Advocacy on limiting births (such as emphasizing environmental, social, and economic benefits)
- Making services available to postabortion and postpartum women

(3) Engaging the field

Interested individuals from the global FP/RH community need to be engaged, and much of the exchange and learning needs to be field-driven. Community members can shift over time among the three levels of engagement: *active participation*, which may involve helping to set the CoP's agenda and working on task teams; a *lower level of participation*, which may entail attending meetings and perhaps taking part in online forums; and *more peripheral engagement*, which could be limited to learning but not contributing.

The LA/PM CoP will seek participation at all levels and will reach out to the field in several ways:

- By establishing a virtual community on the IBP Knowledge Gateway and announcing it through the IBP's network of 3,200 members
- By sharing the agenda developed by the core group and inviting active participation and input (somewhere along the continuum of involvement)
- By inviting all launch meeting participants to inform their field offices about the LA/PM CoP and urge colleagues to join the IBP Global Community and then join the LA/PM CoP
- When online forums are organized, encouraging active involvement of field-based colleagues and counterparts

(4) Recommendations for additional ways to engage the field

- Conduct webinars
- Work through the K4H network to disseminate information
- Involve the field in reviewing, adapting, and translating materials from the implants toolkit
- Think about how the CoP can ensure service delivery and uptake at the field level
- Conduct forums on lessons learned by topic
- Solicit input from clients about satisfaction and dissatisfaction with long-acting methods

VIII. Next Steps



Working groups: Many people signed up for the implants toolkit and research working groups. The initiating partners' team for the implants toolkit will contact interested parties about next steps in the coming months. The CoP Coordination Team under RESPOND will facilitate a meeting to discuss a research agenda most likely in the fall of 2009. Based on suggestions from the small-group work, additional groups may be formed.

Follow-up communication: The CoP Coordination Team under RESPOND will set up an LA/PM CoP page on the IBP portal; this will serve as a conduit for future communication. One such communication to all launch meeting participants will be to elicit input on how the community should maintain regular communications (such as on content, frequency, and mode of contact, and how to ensure that we hear routinely from the field) and on how to nurture and coordinate various efforts to advance access, quality, and use of LA/PMs.

The LA/PM CoP is co-chaired by Patricia MacDonald, USAID/Global Health Bureau/Office of Population and Reproductive Health/Service Delivery Improvement and LA/PM Champion, and Harriet Stanley, Project Director, RESPOND Project/EngenderHealth.

For more information, please contact: info@respond-project.org.