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16 NOVEMBER 2009 – PLENARY

**Moderator(s):** David Serwadda, Makerere University School of Public Health, Uganda

**Family Planning: From Concept to Consolidation**  
**Amy Ong Tsui, Johns Hopkins University**

Dr. Tsui began by stating that her presentation was to be a light overview of the field of family planning and that she sought to address four major points. These included understanding family planning as the diffusion of an innovation, understanding family planning as the demand for a product, promoting the conjugal benefits of family planning and discussing family planning as a social vaccine.

Dr. Tsui began by comparing family planning to other products including Coco-cola and cell phones. She demonstrated that all of these products are diffused according to the social demand that exists for them. In all three cases, the demand is rising. She showed that cell phone coverage in developing countries, which stands at over 50% of the population, is nearly the same as family planning coverage. Family planning coverage in the developing world has risen from approximately 10% in the 1960’s to nearly 63% in 2008. In addition to the increasing proportion of coverage, the number of people using family planning has increased drastically due to increases in population size. Using a chart from the Population Reference Bureau, Dr. Tsui showed the increasing trend in contraceptive prevalence in 5 developing countries over time. This illustrated that behavior change is possible, even in Sub-Saharan Africa, which lags behind the rest of the developing world. She then discussed the use of unwanted fertility as compared to the commonly discussed “unmet need.” Unwanted fertility is measured by looking at whether or not the last pregnancy was desired- both from the perspective of spacing and limiting. This measure is perhaps more straightforward as it is retrospective as compared to unmet need, which prospectively asks women whether they would want more children and whether they are using family planning services.

The next point was the rarely mentioned benefit of the separation of coitus and conception due to family planning. The existence and dissemination of family planning allows men and women to enjoy conjugal relationships without the occurrence of unwanted pregnancy. She showed a graph that charted the percentage of women reporting sex in the past month by the type of method used. This graph demonstrated that women who use contraception report more sexual activity. Although the family planning community does not typically herald this benefit, Dr. Tsui argued that it is an important advantage of family planning and that it should be championed.

Finally, family planning was presented as a social vaccine. Health benefits of averting unplanned births span adult, maternal and child health. Low birth weight, which can occur when births are not adequately spaced among other reasons, has been linked to child mortality as well as Cardiovascular Disease and Type 2 Diabetes in adults. The change in population age structure and demographic dividend has implications for the wealth of families and the economic growth of a country overall. Dr. Tsui argued that family planning is an important social vaccine that should be understood for all of its positive benefits.

**Research Needs for Contraceptive Technology Development**  
**Laneta Dorflinger, Family Health International**

Laneta Dorflinger began her presentation by discussing the need for new reproductive health technologies. She argued first and foremost that the existing technologies do not meet everyone’s needs. Many existing technologies are difficult to use, resulting in high typical use failure rates. Furthermore, many women fail to use contraception due to fear of side effects. For those who do begin using family planning, 25-50% of women discontinue using it within the first year largely due to these side effects. Thirdly, couples’ reproductive needs change throughout the course of their reproductive lifespan. Methods that are acceptable for them at a certain point in time will not necessarily sustain them throughout their reproductive years. Finally, there is a high proportion of women who do not use family
planning. Although this is partially due to limited access, it is also due to dissatisfaction for the currently available services.

Some qualities of a new family planning method include that it should be:

1. Highly effective for typical use: The new method should be forgiving for the mistakes that are typical of typical use.
2. Minimal side effects or even positive side effects (health benefits)
3. Low cost
4. Wide availability: Should be able to be provided by community health workers or be provider independent

The process of product development can be quite complicated and begins with innovation and chemistry in a laboratory setting. From this initial stage, the product moves into animal testing models for safety and effectiveness and into expanded clinical testing. Further human trials follow and ultimately post-trial marketing ensues. This process can take 10-20 years and hundreds of millions of dollars.

Due to a lack of interest from the private sector, most of the innovations in the family planning sector come with public support and public funding.

Some new innovations are on the horizon in terms of contraceptive technology. Cheaper alternatives to existing methods are in demand such as the Sino implant system, a cheaper alternative to Implanon. Methods that are easier to use compliantly (the hormonal vaginal ring) and those that are easier to deliver (Uniject delivery of Depo-Provera) are also much sought after. Finally, there is interest in developing more barrier methods for dual protection such as the SILCS diaphragm.

Other innovations are more in the realm of possibility. Non-surgical female sterilization could provide long term protection for women in need of limiting. Male methods could join the condom and vasectomy as male controlled family planning methods. A peri-coital method would enable coverage for those who infrequently engage in sexual intercourse and are not interested in constantly taking contraceptives. Immuno-contraception could be revisited now that the field of Immunology has developed and more is known about the potential targets for such methods. Finally new methods that offer health benefits could be game changing. Dr. Dorflinger challenged us to consider the possibility of a drug to prevent breast cancer that has the side effect of being a contraceptive. Finally, she suggested that a new commitment from the international community is needed in order to make these new methods a reality.

**Integrating HIV and FP Services: Evidence at Hand, Evidence Needed**

*Michael Mbizvo, World Health Organization*

Dr. Mbizvo’s presentation discussed the need to link family planning and HIV/AIDS programs. He showed that not much has changed with regards to the reasons for the high HIV prevalence. The risk factors remain the same from 10-15 years ago but the prevalence remains high. He suggested that the integration of family planning and HIV could be a means of addressing these high prevalences in generalized epidemics. By combining HIV/AIDS and family planning efforts, service providers can target the same population at once and integrate the facilities for the effective provision of both services.

He cited a recent systematic review of best practices for strengthening the linkages between sexual and reproductive health and HIV. This study included ten peer reviewed studies and six promising practices. He demonstrated that improvements in outcomes are achieved when sexual and reproductive health services and HIV services are combined. These outcomes included reported levels of condom use, numbers of sexual partners, contraceptive use, and reported knowledge and attitudes towards condoms, HIV and STI's.
Dr. Mbizvo showed that integration of services resulted in increased family planning uptake. Patients that receive voluntary counseling and testing for HIV are also more likely than those who do not to use family planning services. Therefore, he showed that linkages are feasible and effective and should be developed. However, more studies regarding the short and long-term benefits of integration of family planning and HIV services are required.

Other linkages with family planning services should also be pursued. Dr. Mbizvo discussed the following areas as potential areas for further integration:

1. Voluntary counseling and testing
2. Behavior change communications
3. Youth
4. Infertility
5. Male services

Dr. Mbizvo ended the session with a quote that demonstrated the need for integrating family planning and HIV services: “We have been mopping the floor but the roof is leaking.” He asserts that integration of family planning and HIV/AIDS services will be more effective and make strides in achieving milestones in both areas.

Estimating Family Planning Costs to Meet MDG 5b

Stan Bernstein, United Nations Population Fund

Stan Bernstein began by discussing the purpose of costing as ensuring that funds were available for service and also to ensure that the funds are delivered upon and that services are provided. In costing family planning interventions, the affordability of interventions needs to be maximized in order to reach as many people as possible. Dr. Bernstein stated that the number of sessions relating to the costing, budgeting and planning of family planning services shows the maturity of the movement.

Costing is a complex process that involves many different levels:

1. Global costing: $23 billion is needed this year to meet the global family planning demand. These estimates are largely for advocacy but also have some practical importance.
2. National Budgeting exercises: Often supported by UN agencies and foundations
3. Road map exercises: An analytical approach to prioritize interventions; in the early years, this approach did not give much weight to family planning services.
4. Investment cases

Costing models need to encompass:

1. Delivery costs: Equipment and supply costs and service delivery costs
2. Programme costs: Investment and capacity building
3. Community efforts: Training and the scale up of trained staff
4. Capital expenses
5. Integration with service packages: Requires additional training

Dr. Bernstein asserted that the challenge of costing is to ensure that family planning funds are protected while at the same time realizing that they are part of an integrated package for maternal health, child health and sexual and reproductive health. He asserted that integration is necessary and needs to be costed and cited postpartum care as a potential area for this integration. Furthermore, approaches to family planning need to be multisectoral and include more stakeholders than solely the Ministry of Health. Outcome measures need to include indicators other than the number of lives saved such as female empowerment and quality of life.
In terms of current gaps in the field, Dr. Bernstein asserted that professionals in the field of family planning need to address bottlenecks, collect gender sensitive statistics and look at cost savings generated from family planning programming. The field needs to show how meeting the demand for family planning can reduce costs later in order to gain political support. Currently there is insufficient money going to family planning. HIV/AIDS work continues as a vertical program and may divert money away from family planning. Dr. Bernstein suggested that this is because the epidemic has a living constituency that maternal mortality and family planning do not have. Dr. Bernstein ended by saying that addressing inequity is absolutely essential to making family planning programs successful.

Discussion

Due to a late start and a shortage of time there was no time for discussion.

16 NOVEMBER 2009 – CONCURRENT SESSIONS

SESSION A01: FAMILY PLANNING AND THE MILLENNIUM DEVELOPMENT GOALS (MDGS)

Moderator(s): Hassan Mohtashami, UNFPA, Uganda; Malcolm Potts, University of California, Berkeley, USA

Presentations

Presenter: Rachel Sanders, Future Groups, United States of America
Summary of Presentation
The presenter singled out the benefits of investing in Family Planning and its contribution to meeting the Millennium Development Goals (MDG). The importance of family planning to achieve the Millennium Development Goals has been underscored. This could provide a high – level advocacy tool for family planning programs. Uganda has an estimated 2.2 million women of reproductive age (15 – 49 years) and that has translated to an annual birth rate of 125,000 per year. The country has one of the highest total fertility rates in the world, standing at 6.7 children per woman. Forty two percent of the women in the reproductive age group want to space their children or even limit childbirth all together, but are not currently using any form of modern contraceptives. This has translated to low contraceptive prevalence rate of 24%. The health benefit of reducing the unmet need for family planning is incredible. If counties were to invest in family planning, governments could save an estimated $ 20.4 million on MDG 2; $ 69 million on MDG 4; $ 74 million on MDG 5; and $ 29 million on MDG 7, a total savings of $ 107 million and 5,513 maternal deaths would be averted. It was concluded that achieving the MDGs by 2015 could pose a huge challenge to the 17 African countries. This calls for universal access to family planning information and services.

Paper 2: Prerequisite to Meet Family Planning Unmet Needs in Sub–Saharan Africa
Presenter: Jean–Pierre Francois Guengant, Institut de Recherche pour le Developpement, Burkina Faso
Summary of Presentation
The presenter documented the achievements of family planning over a 30-year period of programming and strategies to address the unmet need for family planning. Family planning use increased from 10% in 1960’s to 70% in 2000 at an annual increment of 1.5%. In Sub–Saharan Africa, the uptake of family planning uptake has been disappointing in particular. The level of contraceptive use has been estimated at 5 – 30%, even after developing population policies, the contraception prevalence rates are still low. The unmet need has increased over the years. Low use of family planning has been attributed to inadequate access to services, value attached to children, unfavorable environment including strong opposition to family planning and lack of coherence between partners. This calls for a set target of 1.5 point increases per year on Contraceptive Prevalence Rate between 2010 and 2020, integrating sexual
and reproductive health components, scaling up information, education and communication messages for behavioral change and tripling contraceptive supply.

**Paper 3:** Contraceptive Use in Urban Sub–Saharan Africa: Recent trends and Differentials Set in the Policy and Program Context  
**Presenter:** Jean Christophe Fotso, African Population and Health Research Center (APHRC), Kenya  
**Summary of Presentation**  
This study set to highlight the challenges faced in Sub–Saharan Africa. The presenter explained that the total fertility rate decreased from 8 in the 1970’s to 5 in 1990’s. The contraceptive prevalence rate decreased, while the unmet need for family planning and the gap between the poor and rich increased. The purpose of the study was to describe the trend in contraceptive use in Nigeria, Senegal and Kenya; and how these trends vary between urban and rural poor. The survey periods were from; 1990–1993; 1997–1999; and 2003–2005. Current use of family planning was the dependent variable. The results of the study revealed that, fertility has generally stalled in these countries. There was a substantial gap that existed between poor and non-poor in regard to Contraceptive Prevalence Rate (levels and trends by wealth). The presenter concluded that trends in the use of family planning have stalled in urban areas; there was normal gap in Senegal, wide gaps in Nigeria and Kenya between the poor and the rich.

**Paper 4:** Promoting Family Planning within the Context of Environmental Management Yields Higher MDG achievement: Evidence from the Philippines  
**Presenter:** Joan Regina Luponyon Castro, PATH Foundation Philippines Inc, Philippines  
**Summary of Presentation**  
The presenter explained that of the 88.6 million people in the Philippines, 37% were below 15 years of age; 32.9% were poor and this population is growing at 2.04%. The study area is densely populated with an estimated 500 persons/Km². This contributed to a high environmental stress. The IPOPCORM project approach targeted women and youth. The project strategies included capacity building (community and local partners); information, education and communication for behavioral change messages for individuals and communities. The results of the project revealed increased income levels since implementation (MDG 1); increased women’s participation in livelihood activities (MDG 3); uptake of family planning increased by 13 times, unmet need for family planning decreased by 30% among women of reproductive age and a reportedly delayed sexual debut among sexually active young men and women (MDG 5); enhanced community role in protecting the environment (MDG 7); and a balanced ecosystem (MDG 8). It was concluded that the project contributed to the attainment of the MDGs and costal resource management.

**Discussion**

Responding to the concern of whether implementing agencies should invest in vertical or integrated programs, the presenter explained that integrated programs have been shown to be both efficient and effective. Integrating population issues into environmental programs led to conservation of the environment by the peer educators who motivated family planning users. Regarding whether the 1.5 point annual target of Contraceptive Prevalence Rate could be low given the high unmet need, a presenter responded that this was a long-term projection. For example, Contraceptive Prevalence Rate is 14% in Rwanda and 29% in Madagascar. However, the presenter called for a high–level advocacy, committed leadership, and scaled-up funding for sustained supply of contraceptives. The gap between the poor and the rich in regard to access to contraception is due to funding decline in the recent past, stagnation of advocacy efforts and the focus to the urban areas especially in Kenya.

**Key Recommendations**

With 5 years remaining to 2015, when the MDG will be evaluated against the set targets in 2000, it was recommend that implementing partners must do things ‘differently’ (be more innovative, proactive).
SESSION B01: MEASURING AND RESPONDING TO UNMET NEED

*Moderator(s):* Christopher Garimoi Orach, Makerere University School of Public Health, Uganda; Henry Mosley, John Hopkins Bloomberg School of Public Health, USA

**Presentations**

**Paper 1:** When One Size Doesn’t Fit All: Using Client-Centered Market Segmentation Analysis to Tailor Family Planning Interventions in the Philippines  
*Presenter:* Sara Sulzbach, Abt Associates, Inc., United States of America

**Summary of Presentation**

This study set out to investigate how Client-Centered Segmentation (CCS) as an analysis tool can be used to aid family planning (FP) programs in tailoring their interventions and messages to the needs of specific segments of the population in the Philippines. According to the presenter, the reason for this study stemmed from the fact that Philippines has been experiencing a contraceptive plateau, and the thought was that by getting more information on behavior of respondents, BCC programs would be tailored. A sample of 1000 women aged 18-49 years was selected for the study and the hybrid methodology was employed. The presenter emphasized that family planning programs need to be tailored to specific subgroups as opposed to generalized campaigns that may fail to address differing needs, values and attitudes of the diverse population segments. The presenter further added that this was a recent study to add unmet needs by identifying unique segments of the population. She also pointed out that CCS has frequently been in the family planning arena and focuses on physical dimensions that are geographical, socio-economical and demographic. Markets are really not homogenous and so there is a need to understand different segments of the population. Six unique segments of the population were developed from the analysis, though major focus was placed on only two groups that were largely similar. That is the “Aware Ambivalents” (35-49 years) and “Prudent Urbanites” (35-49 years). The study adopted the BCC model to present results. The conservatives who exhibit positive attitudes towards FP and intend to use contraception in the future, are in fairly early Stages of Change (SOC) and are difficult to influence to adopt some FP methods as compared to ambivalents. Most groups are still on the left side of the SOC. This shows that there are still more opportunities and more work needs to be done to get groups to practice change.

**Paper 2:** Understanding Unmet Need: Changes in Measurement Overtime in the Demographic and Health Surveys  
*Presenter:* Sara E.K. Bradley, ICF Macro, United States of America

**Summary of Presentation**

The presenter stated that generally unmet need is perceived as the percentage of women who do not want to get pregnant, but are unable to devise the means of preventing it from happening at an unplanned time. Unmet need is not widely understood by people and it is difficult to measure. However, it is increasingly used for advocacy, development of FP policies, implementation and monitoring of programs worldwide. This study investigated different ways in which the definition and calculation of unmet need has been applied to different rounds of Demographic Health Survey (DHS) data. Since its adoption as a Millennium Development Goal indicator, understanding unmet need has become very crucial. The presenter emphasized that it is also important to understand the comparability of unmet need over time, which has become difficult as it has been applied in different ways to different DHS rounds over time. One of the major aims of this study is to provide a consistent definition to be used across countries and time in DHS surveys. The variations in definitions in DHS over time, that made variables incomparable, calculations complex and compatibility generally inconsistent, got the presenter and co-researchers thinking to start looking at other new definitions that are simpler to use across countries, time frame and that can be used elsewhere other than the DHS. The research team hypothesized that applying the current definition of unmet need to earlier surveys will only slightly change older estimates of unmet need calculated in previous rounds. And that if the calculation of unmet need is widely understood and there is a consistent definition, a wider audience will more easily interpret this indicator, making it more appropriately used as an MGD indicator. The presenter showed the audience how unmet need is calculated, using countries with multi surveys as examples to demonstrate impact of the current
definitions. Approximately 122 surveys in 45 countries were analyzed. There was only marginal change in levels of unmet need when the current definition was applied retrospectively. For instance in Uganda, application of the current definition changed the total unmet need estimate among married women in 2000 slightly, from 34.6 to 34.7 percent. From the results, changes in levels of unmet need due to different definitions are rather small and so do not appear large enough to change any program or policy recommendations of a country.

**Paper 3: Building a Balanced Method Mix: The Potential Sustainability of Low-cost Implants in Family Planning Programs**  
**Presenter:** Alice Olawo, Family Health International, Kenya  
**Summary of Presentation**  
In this retrospective cohort study carried out in Kenya, the research team assessed the actual amount that contraceptive implant users in Kenya are currently paying for insertion and removal and potential barriers to introduction of lower cost implants that exist in Kenya. These influence the sustainability of implants in family planning (FP) programs, as they have an important role to play in the FP method mix. The presenter explained that data was collected using mail/telephone surveys and interviews with current and returning implant clients. Though static and mobile clinics provide implants, they are still underutilized in Kenya despite their known effectiveness, but this is changing due to the fast approaching low-cost implants. In comparing the two types of implants, Sino and Jadelle, the former is effective for up to 4 years, distributed using disposable trocars to prevent HIV transmission especially during insertion and the cost is relatively cheaper as compared to the latter, Jadelle. Currently Sino implant is the cheapest FP method and is registered in Kenya. The key finding is that cost recovery is possible as a result of the payment interactions from the Public, Private for profit (PP) and the NGO sector. Those in the NGO sector are already paying enough ($20), and those in the PP are also willing to pay up to $27, meaning cost recovery is possible. Donor reliance will then be reduced as far as giving out or distributing implants is concerned, and will also contribute to lessening of stock outs. 92% of clients had access to removal, showing the need to focus on high cost of implant removal especially in the NGO sector. Existing barriers to introduction of implants in FP programs were fear of side effects and lack of information on this particular method, which barriers can all be addressed through a comprehensive provider counseling program. Though these barriers make use of implants seem unacceptable, majority of the clients still use it. This response would not be enough to deter other women from using this method.

**Paper 4: The Short Form (SF)-36 Health Survey Questionnaire as an Outcome Measure in Contraceptive Research: Results of Phase 1 of the Health Related Quality of Life Changes among Users of Depo-medroxyprogesterone acetate (DMPA) Trial.**  
**Presenter:** Sikolia Z. Wanyonyi, Aga Khan University Hospital, Kenya  
**Summary of Presentation**  
We all know that contraceptives are often a lifestyle choice, as evidenced by most mothers who visit health care facilities. The research team realized that this was impacting the quality of life (QoL) as mothers returned to clinics/hospital with feedback like; they are having normal menstrual patterns, sexual life, and blood flow. The researchers through this study looked for objective ways of assessing benefits mothers derive from contraceptives vis-à-vis their QoL, thus the employment of the SF-36 health survey tool. However QoL tools have not been adequately assessed in populations. The mode of administering this tool was through telephone and an interview questionnaire. The presenter explained that study was quite turbulent as there was loss to follow up and refusal by potential respondents to participate. However, intended results were still realized as most of the questions had a good correlation and reached the measurable criteria of 0.4 and the sample size selection was well powered to detect a 5 percent change in a period over time. Findings revealed that the tool is quite reliable, internally consistent and acceptable as a measure of health status among contraceptive users. In most aspects the researchers wanted to assess such as pain, social and physical functioning, mental and general health among others. General health did have a very low correlation as compared to the other aspects and thus currently a qualitative study on how mothers interpreted some of the above aspects is on going to determine if these interpretations had an influence on the very low correlation for general health. As the study population was mainly urban and well educated, these findings could not be generalized to the entire population. The presenter made recommendations that QoL tools need to be adequately assessed and tested in
populations particularly with low socio-economic status and in the rural areas. It should also be used by other researchers and FP providers if found reliable.

**Paper 5:** Estimation of the Total Fertility Rates and Proximate Determinants of Fertility in North and South Gondar zones, Northwest Ethiopia: An Application of the Bongaarts’ model

**Presenter:** Getu Degu Alene, University of Gondar, Ethiopia

**Summary of Presentation**

Studies show that each year about 80 million new people join the human race, which is roughly equivalent to the size of the Ethiopian population. Total Fertility Rate (TFR) is the most commonly used and important measure of fertility. Ethiopia is ranked only 2nd to Nigeria with a projected population of 82.5 million people in mid 2009. The presenter strongly emphasized that uncontrolled fertility levels in Ethiopia has adversely influenced the demographic, socio-economic and environmental situations of the country. This cross sectional study addressed issues relating to the intermediate determinants of fertility in two major zones in Ethiopia and how these variables can lower the fertility rates, and also highlighted the TFR estimates in these two zones. The presenter explained that the Bongaarts’ model was employed in a sample size of 3512 women of reproductive age, to estimate the fertility rates and quantify the contribution of each of the proximate determinants of fertility. The overall TFR of both zones was computed and estimated at 5.3. In addition, post partum infecundability resulting from prolonged breast feeding was the major proximate determinant to lower fertility in both zones, followed by contraceptive use and not getting married. There is need to encourage and improve contraceptive use especially in the rural population and a collaborative effort by both local and international agencies/institutions to promote breast feeding.

**Discussion**

The fourth presentation about the (SF)-36 health survey questionnaire as a quality of life tool had most reactions with similar questions from a considerable section of the population regarding its strength. This tool was considered by some audience members as something that would not be that reliable in measuring or assessing the effects of contraceptive use on quality of life, although the audience agreed that it was quite comprehensive. The presenter explained to the audience using examples of some of the over 4,000 publications worldwide that have used this tool and that what you get is actually what you intend to measure. Adding that like other medical outcome survey tools, the SF-36 is an acceptable, internally consistent, reliable measure of health status among contraceptive users. The audience also voiced concern about the fact that this tool may need knowledge, so what about the mothers, most of who have tertiary education. Responding to this, the presenter stated that these tools are translated in the local dialect for easier understanding and comprehension. A reproductive health expert from India commented on the new definition of unmet need, saying he was instrumental in helping the government of India use this definition as in his view, he felt it was the best method. This was after they were forced to use the international definition and he had an opportunity to compare them. The study was commended however for clearly bringing out and explaining the standard and new definitions of unmet need. The audience thought that if the new definition works better as presented to them then, the economic potential benefits should be passed on to policy makers of their respective countries.

**Key Recommendations**

It was recommended that the researcher should consider educating or training particularly the rural women and those with low education levels about the SF-36 health survey questionnaire. Considering that the SF-36 health survey tool has not been adequately assessed in local populations, it was recommended that the tool be tested in the rural populations and among those with low socio-economic status. In the event that the tool is found reliable, then it can be nationally or globally adopted for use by especially researchers and family planning providers. Just like the researchers in the second presentation highlighted, there is need for further research to determine whether differences in unmet need due to changes in definitions are consistently negligible across countries and time points.
SESSION C01: FAMILY PLANNING FOR VULNERABLE POPULATION

**Moderator(s):** Richard Kawooya, Marie Stopes, Uganda; Shelley Snyder, USAID, United States

**Presentations**

**Paper 1:** Innovative effective approaches for increasing Family planning service access in difficult settings of Liberia  
**Presenter:** Clarence Massaquoi, PMU-Liberia  
**Summary of Presentation**  
Astarte state project model was used to provide seed grants for local NGOs in conflict areas and provide: technical training, organizational strengthening, and linkages (at the regional, international and community levels). This helped in recognizing the capacity of local NGOs in the provision of FP/RH services, which turned out to be cost effective. Inputs for the project were: proposal writing, $10,000 grant, M&E training, organizational development and leadership training, RH training and materials, and networks training. Promoted life saving services, scaled up the services and ensured continuity. The project strategy also involved training traditional midwives who were to implement the service that increased the access to FP. In conclusion, with appropriate support, local NGOs are best positioned to provide effective, culturally acceptable, and relevant RH and FP services, especially in conflict and transitional settings.

**Paper 2:** Targeting public sector resources and effects to improve access to FP services among the poor in Peru  
**Presenter:** Suneeta Sharma, Futures Group International, United States of America  
**Summary of Presentation**  
The presentation stated that over 50% of the population in Peru is below poverty line. In 1995 the contraceptive use increased from 20 to 32 because it was free of charge and the reliance to public sector increased between 2002 and 2003. The rich utilized public sector for FP services while the poor utilized traditional methods for FP services. A multi sector approach was designed to address the problem. This policy addressed the lack of accurate and culturally appropriate information, limited financing for training and monitoring IEC for FP, and the lack of incentives to providers in the integrated health model. Strategies like operationalizing RH information in JUNTOS (conditional cash transfer program), mobilized regional funds for IEC and improving quality service, ensured inclusion of FP in the social insurance scheme for the poor in Peru (SIS). It was learned that to effectively reach the poor in Peru, you must: understand policy environment, support country-driven processes, involve the poor in identifying problems and designing solutions, build on existing mechanisms, design financially sustainable solutions, implement evidence-based targeted interventions and conduct equity-based M&E.

**Paper 3:** Family planning as a basic life saving skill: Lessons from Africare’s Program in Rural Liberia  
**Presenter:** Rachel Criswell, Africare-Liberia  
**Summary of Presentation**  
She noted that Liberia had a population of 3.5 million and 51% of the population is under 21 years. The life expectancy was 41 for males and 43 for females. The MMR was 994/100,000, CMR 110/100,000, TFR 5.2 and teenage pregnancy being at 68% SGD -93%. There are 325 certified midwives (1:100,000) and 87 doctors (1:40,000). The CPR- 11% unmet need – 36% (LDT2000). Hormonal pills were consumed to 28% condoms 33%, injection 39% while the long acting were not at PHC level. In the country BLSS was done which included task shifting, training clinicians and FP was part of BLSS. The training was in theoretical IUD insertion while the practical IUD was in hospital. The UNFPA provided the IUDs. Results showed an increase in CYP, IUD insertion although it was a small percentage. Insurance practical training was necessary while theoretical training affected influenced choice while longevity decreases over time. Recommendations include: ensure that all training includes practical training, especially for more complicated skills; incorporate other elements into training, such as support supervision, follow-up and behavior change communication; and supplement with community mobilization, especially to increase demand of long-acting contraception.
Paper 4: Reproductive health commodity security in post conflict situation, a case of northern Uganda  
Presenter: Sarah Mbabazi, Programme for Accessible Health Communication and Education (PACE), Uganda  
Summary of Presentation  
The overall goal of the pilot project was to contribute to the improvement in the reproductive health commodity security especially contraceptives and condoms at district and lower level health structures in Uganda. The study was intended to contribute to an environment that enables the populations in Kitgum and Padel districts (that had been affected by war for over 20 years) to enjoy constant and reliable availability of RH commodities to meet their RH needs. Specific objectives were: to ensure the availability of RH commodities at all levels of the supply chain, to build the capacity of key personnel at UNFPA and MOH in RH commodity security; to build the capacity of districts and health facilities at all levels in logistics management and to create client demand for utilization of RH commodities at the community level. Most of the people were displaced in camps which had poor logistics and management, PPP intervention and low political commitment. A five year RH development strategy was developed. Stock outs were (RH) reduced lead time was reduced from 60 days to 3-4weeks increased client load for FP and improved LMIs at health facility level. It was learned that partnership was not equal but important in learning from each other.  
Discussion  
Different points were brought up on the challenges in the Peru project, the strengths of networking, differentiating the needs of the urban poor and local rural poor, and the reduction of lead time (NMS).  
Key Recommendations  
- Appropriate support to local NGOs provides effective, culturally acceptable. Relevant RH/FP services especially in conflict and transitional setting.  
- Involving cultures in developing policy was crucial in providing financial solution, evidence based intervention, and equity based M&E.  
- Ensuring training and support supervision was essential for improving FP/RH ser  
- PPP is key in ensuring FP, RH service provision.  

SESSION D01: INTEGRATING FAMILY PLANNING (FP) AND HIV PROGRAMS I  
Moderator(s): Olive Sentumbwe Mugisa, WHO, Uganda; Michael Strong, US Embassy, Uganda  
Presentations  
Presenter: Ibrahim Kirunda, Quality Improvement Advisor, USAID Health Care Improvement Project University Research Co., LLC, Uganda  
Summary of Presentation  
The presenter shared the experiences on a USAID-funded collaborative project that is currently providing antiretroviral therapy (ART) in 183 sites in Uganda. The presenter noted that the stigma that HIV-positive clients face affects their decision making when it comes to FP. However, FP offers the benefit of delaying pregnancy and optimizing maternal health. The research sought to improve FP care for HIV-positive clients. To do this, the researchers developed 3 quality improvement (QI) indicators for periodical evaluation of the sites. They trained providers at 13 sites to document and offer integrated HIV Care/FP services, and then monitor sites performance using FP-HIV care indicators. There was a rapid increase in the number of HIV-positive clients counseled on FP methods when their work was initiated. The presenter indicated that, the facilities now provide FP methods as part of the routine care, which never used to be
the case. The main lessons learnt was that trained providers can do better when they are supported and missed opportunities can be reduced through integration of services.

**Paper 2: Integration of Family Planning Services into Community-Based Care for People Living with HIV in Ethiopia**

**Presenter:** Medahnit Wube, Family Health International (FHI), Ethiopia

**Summary of Presentation**

Since 2007 when FHI initiated work with partners in Ethiopia to integrate sexual and reproductive health (SRH) services; especially in FP, integration in 14 sites across four major regions in Ethiopia has been made. But why should FP and HIV services be integrated? The presenter asked rhetorically. She answered her question saying that more than 50% of HIV clients on ART are sexually active and need discussions on fertility issues. But among them there is unmet need for contraceptives. Using a series of seven steps, the presenter explained how their work resulted in an increase in uptake of oral contraceptive pills from 2007 to 2009. Within the same period, uptake of injectables also increased, but not in the same magnitude. The presenter noted that one major lesson they learned was that home and community-based programs are an appropriate and effective entry point for reaching people living HIV with important SRH information and services. The presenter concluded that community based service providers can play an important role in increasing access to family planning services and helping HIV-positive individuals understand their reproductive choices.

**Paper 3: Policy and Operational Barriers to Family Planning and HIV Integration in Kenya**

**Presenter:** Colette Aloo-Obunga, Futures Group International, United States of America

**Summary of Presentation**

The objectives of this study according to the presenter were to identify and document policy and operational barriers of RH/HIV services, and also to identify achievements of existing RH/HIV integration interventions in Kenya. To do this, four provinces were identified and respondents purposively sampled. They included national policy makers, program managers, and service providers. The presenter indicated that their study resulted in benefits both to the clients and to the providers. To the clients, there was greater access to services, there was improved quality of services, and they were empowered to make informed choices. Benefits to providers included comprehensive service delivery, use of standardized training materials and so more efficient time management. The presenter, however, lamented that despite these clear benefits to the clients and service providers as a result of RH/HIV service integration, policy and operational barriers exist thereby preventing effective integration. The main barrier according to the presenter was the lack of a national policy and guidelines to address the barriers. Others included no budget to support their work, absence of clear monitoring and evaluation indicators, and staff shortages. The presenter was, however, optimistic that if these problems are addressed, integration will be feasible and will be supported by the Kenyan public health system.

**Paper 4: Without Strong Integration of Family Planning into PMTCT Services Clients Remain with a High Unmet Need for Effective Family Planning**

**Presenter:** Jennifer Asuka Leslie, Family Health International/Rwanda Country Office

**Summary of Presentation**

The presenter talked about the fact that the Rwandan government recognized the importance of FP as a priority for economic development, and so initiated FP-HIV integration in 2007. The objectives of the study among others was to determine the need for FP among PMTCT clients after birth; determine readiness of antenatal care (ANC) and postnatal care (PNC) providers to offer FP. Managers, providers, HIV-positive female clients seeking services, as well as their male partners were invited for interview. Thirty health facilities with integrated services were reported as already being in place in 15 administrative districts. The presenter indicated that majority of women seeking PNC in this study reported already using contraception. Some, however, identified themselves as not needing any contraceptive method. Only 12% identified themselves as having an unmet need. The presenter was, however, quick to add that it may be an under-estimate. The presenter also stressed that though expressed unmet need for FP was low, nearly half of the women using contraceptives rely on male condoms, and many women reported not having used them at last intercourse. This inconsistent use puts women at risk of unintended pregnancy.
Discussion

A lively discussion followed the presentations. One of the moderators introduced the discussion session reiterating the challenges declared by the various presenters on the topic of “Integrating FP with HIV programs.” The challenges she said were real, but with a thoughtful implementation of the suggestions and recommendations given by the presenters, those challenges can be overcome. The good news she added is that both programs are targeting the same population. There was a question directed at the fifth presenter on the reasons given by the clients in the study who opted not to use FP commodities. The presenter competently addressed it saying those who identified themselves as not needing contraception said they were not yet fecund, or had not resumed sexual activity. There was a contribution from the audience on the need for all governments to take the challenge to address all policy and operational barriers to integration. The presentation on “strategies used by facilities to integrate FP into HIV care…” generated a number of burning issues. One of them was how the presenter and his co-investigators addressed the lingering problem of hesitance by clients to attend counseling and receive FP information as a result of stigma related to HIV infection. He indicated that, through health education at the facility level, and the involvement of religious bodies at the community level, they were able to deal with this issue. The presenter added that, integration itself is seen as a way of dealing with the stigma. Reacting to another question from the audience on the issue of shortage of staff as a barrier to integration, the presenter offered a number of solutions including improving the professional quality of already existing staff through continuous medical education and encouraging staff to work in teams. The third presenter, reacting to the question on why long term FP methods not patronized in Ethiopia, explained that these methods are offered to clients by providers but clients frown on them because of popular misconceptions and misunderstanding of their side effects. The presenter added that there are even rumours currently being spread in the country that HIV+ women should not use IUDs. Finally the issue of some providers offering FP not to help HIV-positive women make informed choices about birth spacing and limiting the number of children, but simply to encourage them not to have children at all was discussed. This attitude according to the moderator, some of the presenters as well as some audience seems to reflect a tension between prioritizing prevention of pregnancies and protecting women’s reproductive rights.

Key Recommendations

The key recommendations from this session were to provide quality FP and HIV/AIDS services in an integrated manner. In-depth FP trainings and development of quality improvement indicators for health providers should be implemented. The harmonizing of FP-HIV Care/ART integration services with all the relevant partners is important. Integration of FP and HIV care should be vigorously pursued because it makes effective utilization of scarce resources. To be able to do this, support from the national level is needed. Finally, there should be proper operational guidelines and monitoring and evaluation frameworks to help guide and monitor integration efforts.

SESSION E01: CONTRACEPTIVE TECHNOLOGY I

Moderator(s): Noah Kiwanuka, Makerere University, Uganda; Anne Burke, Johns Hopkins University, USA

Presentations

Presenter: Aida M. Cancel, Family Health International, United States of America

Summary of Presentation

The presenter mentioned that the Sino-implant (II) which was introduced by Shanghai Duhua Pharmaceuticals and had been used in China for more than 15 years was more available and cheaper on the market than any other existing implants. An evaluation was carried out to explore the product quality and whether it had met internationally standards for use. The presenter noted that tests were done by specialists in quality assurance on the active ingredient Levonorgestral and on the final product (Sino
implant II rods) as well as the final packaging material. The tests were done by two laboratories and standards approved by China State Food and Drug Administration (SFDA). It was found that the tested implant met the ISO, USP / ASTM standards. The quantities of Zinc and Aluminium that were found in the Sino- implant (II) were below USP accepted parental daily limits. While the inorganic impurities present were similar with those found in Jadelle samples which makes it safe for people to use. The presenter said that all the residual solvents and endotoxin levels were way below the medical standards accepted on devices and were harmless to the body. The tests met all the required tests for packaging and that it would be accepted internationally. In conclusion the presenter disclosed that the program for quality assurance and testing was on-going until 2013 when the product will be widely availed to the public and that Duhua Pharmaceuticals Co. was capable of producing quality Sino II Implants.

Paper 2: Expanding Contraceptive Options in South Africa: Knowledge, Attitudes, and Practices Surrounding the Intrauterine Device
Presenter: Sarah A Gutin, Women’s Health Research Unit, School of Public Health and Family Medicine, University of Cape Town, South Africa
Summary of Presentation
Although studies show that the copper T IUD is the most safe, highly effective, long lasting method of contraception, its utilization in South Africa is really low despite it being administered free of charge. The study sought to assess the knowledge, attitudes and practices of IUD users and service providers on 205 clients and 32 health providers. According to the presenter, the providers had inadequate knowledge of IUDs and that they needed more training. Many providers thought that IUDs caused PID. In addition, some clients believed that IUDs could increase a woman’s chance of getting an STI, was effective in preventing pregnancies, and easier to use than a TL. The study was limited to only those women who had attended the clinic and to only a few providers. Few women knew actually about the IUDs, significantly none of the participants knew that the Copper T could be used for more than 5 years. This opportunity calls for teaching women about IUDs. The presenter made recommendations that to teach and sensitize women on IUDs, equip health providers with skills and knowledge on administering the IUDs to clients.

Paper 3: Feasibility of Over-The Counter provision of SILCS diaphragm: experience of women inserting and positioning the device after reading written instruction only in the pivotal trial
Presenter: Jill L Schwartz, CONRAD/Eastern Virginia Medical School, United States of America
Summary of Presentation
In this study, 450 couples were studied to examine the effectiveness and safety of the single-sized SILCS diaphragm contraceptive developed by PATH. The on-going study which started in 2008, will have results of the trials in 2010. The study explored the feasibility of the OTC provision of the diaphragm and the ability of the women to use it rightly. Most participants knew how to insert the SILCS diaphragms however with few finding difficulties as they felt pain behind the pubic bone. There were no demographic factors to predict lack of fit for the device. The product was found to be highly effective with no pregnancies reported for its use. The presenter recommends the need for written instruction on the manuals to be improved to suit different users as well as reach out to many LDCs.

Paper 4: Development and Acceptability of the NES/EE: A Year-long, User- Controlled Contraceptive Method
Presenter: Ruth Merkatz, Population Council, United States of America
Summary of Presentation
In this study, population council had reached the later stages of developing a long lasting hormonal Contraceptive Virginal Ring that contains Nestrone (NES) as one of the efforts to reduce on the unmet need for contraception in the world. The presenter affirmed that the developed CVR was undergoing tests on different populations to ascertain its effectiveness and usability. The ring which can easily be inserted and removed by the woman was designed to be used for 13 cycles equivalent to a year. The ring can remain in the vagina for 3 weeks and a break of 1 week per cycle. The study was in its preliminary stages and would soon seek for approval from WHO in order to avail the product on the market. According the FDA standards, the tests had met them as evidenced with the rapid return to fertility, it appeals to all women with short or long cycles and the high user satisfaction among other things. It was established that
some women found difficulties associated with adherence to instructions, its effects on sexuality and fear of side effects. The presenter recommended the need for follow up on women who had complaints about the method as they were more likely to discontinue its use hence get pregnant.

**Paper 5: Increasing Access to Injectable Contraceptives; Introduction Depo-SubQ Provera 104TM in the UnijectR Device**  
**Presenter:** Sara Jane Tiff, PATH, United States of America

**Summary of Presentation**  
Studies show the global demand for injectables will increase by 2015 meanwhile the discontinuation rate in developing is high due to accessibility, time taken to get a product and costs implied in getting the service. The study set out to generate data and experiences to inform introduction plans for depo-subQ in Uniject, focus countries to develop introduction plans as well as create an environment for the readiness for the product. The Depo-subQ provera 104 is an injectable contraceptive that is administered every three months, it contains 104mg of DMPA which is packed in a uniject. The presenter mentioned that Depo-SubQ in uniject had benefits related to service provision especially in relation to storage, distribution and waste disposal. In addition the easier to use contraceptive could easily be administered by a community health worker and that it had a single doze pre-filled in the uniject. Initial findings show the device was time saving, it required reduced training time and costs. It also has potential influence community accessibility and policies in the country. In conclusion, the presenter said that systematic, action driven introduction planning for depo-subQ inject is anticipated to increase access to injectable contraceptives.

**Discussion**

Questions were raised to paper one presenter about product similarities with Jadelle, how far they had reached with seeking WHO approval and whether the product was available in the market. In response the presenter said they were not seeking for WHO approval as the product was still being developed, she however revealed that the product was available on the market though not widely spread. In relation to similarities with jadelle there was some likeness however controls and testes were being made by Population Council to ensure the product was appropriate and not a replication of jadelle.

Paper 2 presenter was asked whether during the study they asked the clients the contraceptive method they were using, whether they had a reason for using western Cape as a study area, whether the results would be different or significant if it was another study area. One of the participants wanted to know about the perspective of the husbands of the women using the IUDs. In reaction the presenter said, though the women asked about their husbands’ perspective, they were remorse in answering, so the results were not captured. The question about the asking what the women were using and whether the results would be different from the current findings was not answered by the presenter.

As regards to the Over the Counter SILCS diaphragm presenter, how soon could a woman have diaphragm after delivery, the other participant wanted to know how much it would cost on the market and how soon they would be availed. Another participant was concerned about the tests for sensitivity to silicon and the buffer gel used with the diaphragm. In response the presenter said that there were few severe reactions to the diaphragm and that they were yet to carry out those sensitivity tests. He further said that the product will be available in the market in the next 1-2 years at a cost of less than US $2 as they were still seeking for approval from WHO.

As a comment, one participant mentioned that the Over the Counter SILCS diaphragm would be for only literate societies leaving out regions like Sub-Saharan Africa. She pointed out that most women in this region are illiterate hence they would not be in position to use that product that requires reading instructions before use. She further wondered if that product would be viable in societies that do not have access to clean water and would ensure usage without infections. Since a woman has to insert it by herself, how can we be sure that her hands are clean after a day’s work in the garden?
Key Recommendations
Since the Sino (II) met the required tests it should start seeking for approval from WHO so that it can be widely accessed by the different populations. While designing Over the Counter implants it is important that both literate and illiterate societies are put in to consideration. Measures should be put in place to ensure communities with poor sanitation environment are catered for. There is need to train and sensitize communities, health providers on the benefits of using IUDs. This will help scale up the use of IUDs and demystify their beliefs, attitudes and perceptions of some potential users against IUDs. The improved contraceptives have a lot of potential in reducing the high unmet need for contraceptives in the world. Efforts should be towards product completion and getting approval so that they can be availed in the market for use.

SESSION F01: EFFECTIVE PROGRAMMING AND SERVICE DELIVERY

Moderator(s): Henry Kakande, STRIDES Project, Uganda; Kathryn Panther, USAID, USA

Presentations

Paper 1: Client and Provider Perspectives on Barriers to Family Planning Quality in Kenya: Assessment and Programmatic Implications
Presenter: Constance Ambasa-Shisanya, Family Health International

Summary of Presentation
Researchers collected qualitative data from four health facilities in Kenya with the intention of improving communication between clients and providers by developing a lexicon to clarify terminology to use in FP counseling visits. Information was collected from clients and providers via exit interviews, recorded provider/client interactions, provider encounter logs, in depth interviews, and clinic data abstractions. The analysis revealed several limitations in service delivery, including (1) the fact that returning clients do not receive adequate counseling on issues such as side effects (2) group counseling is problematic in terms of confidentiality and privacy, and (3) provider disposition, such as facial expressions, may hamper interactions with clients. New clients had a median visit time of 11 minutes, while returning clients had about 5. While concepts and terminology were understood by the majority of clients (93%), some terms (such as “family planning”) carry negative connotations, and should be replaced with more locally acceptable terms such as “spacing births”. Providers also reported structural challenges such as lack of space, equipment, staff, or supplies. A poster hung in the clinic encouraged clients to think about what concepts they wanted to discuss during their counseling session, and included laminated cards used to prompt discussions on specific concerns. Data are now being analyzed on the effects of this poster.

Paper 2: Evaluations of the Impact of Quality of Care Interventions on Clients Behaviors in Three Countries
Presenter: Ian David Askew, Population Council

Summary of Presentation
Three studies in Egypt, Uganda, and Peru addressed quality of FP care by addressing three major questions: (1) Can context-specific interventions be implemented that strengthen system readiness, and enhance clients’ rights to receive quality of care? (2) Can these interventions make measureable improvements in client-provider interactions? (3) If quality of care is improved, what is the effect on client outcomes? Each country received a package of system, provider- and client-oriented interventions. These interventions significantly improved quality of care in Peru and Egypt, but results were mixed in Uganda. In the two countries where the interventions had been successful, a longitudinal study was mounted to assess the effect of improved quality of care on client outcomes, and investigators found that knowledge and method satisfaction improved, but the intervention had no effect on rates of method switching nor on all method 12 month cumulative continuation rates. Although increased quality of care did not lead to major sustainable improvements in client outcomes, the presenter raised the interesting point that good quality of care is a right, so the importance of evaluation of the effect of increased quality of care are debatable.
Paper 3: Impact of Exposure to Family Planning Interventions on Use of Modern Family Planning Methods in Nigeria  
Presenter: Fatuma B. Muhammad, Society for Family Health, Nigeria  
**Summary of Presentation**  
A project entitled Improving Reproductive Health in Nigeria (IRHIN) aimed to improve understanding of, access to, and demand for contraception, by developing an intervention which involved components related to service delivery, advocacy (particularly around religious and cultural sensitivity to acceptance of FP, as well as male involvement), community level FP distribution, stock out prevention, and community mobilization. A quasi-experimental design evaluated the impact of the intervention by taking baseline measures in three states of Nigeria and assessing differences in knowledge and use of services among 1800 women (powered to detect a 15% change in certain indicators). The researchers found 1.6 times higher use of FP in intervention communities, as well as an increase in use of health facilities for other health issues. Adopting integrated approaches are likely to have individual and community level impacts, and scaling up similar interventions should be given adequate attention.

Paper 4: District Participation in the Selection of Project Target Zones for Delivering Family Planning Services in Uganda  
Presenter: Elke Konings, Management Sciences for Health, Uganda  
**Summary of Presentation**  
Despite investments of donors, implementing partners, and others, rates of fertility, maternal mortality, and under-five mortality in Uganda have not changed in a decade; suggesting that new approaches are needed. The STRIDES project aimed to change the way districts targeted for family planning service improvements are selected, by instituting a competitive district selection program, hoping to attract involvement from highly motivated districts who would then see themselves as stakeholders in success, and accountable for achieving gains in FP use. The high response rate indicates that this new approach was welcomed, and that selection based on motivation might be an effective strategy, but it is still unclear whether this approach will lead to improved results.

Paper 5: Increasing Couple Years of Protection (CYP): Successful Strategies from a Community-based Family Planning Program in Uganda  
Presenter: Paige Anderson Bowen (Minnesota International Health Volunteers)  
**Summary of Presentation**  
A community based FP program run by Minnesota International Health Volunteers (MIHV) in 2 districts in central Uganda facilitates access to FP by: expanding service delivery, piloting alternative delivery mechanisms, education, mobilization, building capacity, collaborating with other stakeholders, and engaging men and community leaders. FP data was collected semi-annually from district health management information systems, and showed an overall increase in couple years of protection of 50% over 2 years. It is difficult to know which component of the program was most successful, but program elements were described in detail. This program could be used as a model for other programs.

**Discussion**

Regarding the intervention in Nigeria which increased FP use, audience members wondered if other projects were ongoing at the same time that might have influenced the results. Fatuma Muhammed responded that there were no similar ongoing FP projects in the North, but there were HIV/AIDS programs, and that there were no similar programs in the South. Discussion also focused on the difficulty of involving religious groups, and Fatuma Muhammed suggested using appropriate terminology (such as “child birth spacing” instead of “family planning,” which carries bad connotations).

Ian David Askew was asked whether the three countries he studied had national FP standards, and how often they are monitored. All three countries do have standards, but there is a challenge of applying standards to different contexts, and it is not clear how to assess standards, but we need to look at quality assurance efforts. He emphasized that he wants to move the field towards focusing on quality of care, and not necessarily on contraceptive continuation rates.
Some discussion occurred regarding the inadequacy of the average length of time for provider client interactions in FP visits for continuing clients (5 minutes). Audience members and panelists agreed that 5 minutes is too short for exams, counseling, and other activities, and the presenter hopes that indicators will improve after introduction of a balanced counseling strategy.

One audience member asked the panelists how they care for individuals with disabilities such as deafness or blindness, since these people face special challenges to getting quality FP care. None of the panelists responded.

**Key Recommendations**

Interventions must take structural challenges into account; providers are constrained from providing quality of care by the resources they have available. Language used and the behavior of providers (such as body language or facial expressions) is important to consider in terms client comfort. A longitudinal study showed that improved quality of care may not lead to major sustainable improvements in care. Still, quality of care is a right. Job aids should be used to help provider communication and client understanding. Effective intervention packages which integrate multiple components (such involvement of men, religious leaders, and the community) can be effective at increasing use of modern FP, and potentially also increasing other health-seeking behaviors. New approaches to the ways in which donor funded projects choose target districts, such as implementing a competitive system for selection, seem to generate enthusiasm. It remains to be seen whether such an approach will lead to improved FP outcomes.

**SESSION A02: REACHING YOUTH: PROGRAMS FOR ADOLESCENTS**

*Moderator(s):* Robert Blum, Johns Hopkins Bloomberg School of Public Health, USA; Abeja Apunyo, Pathfinder International, Uganda

**Presentations**

**Paper 1:** A Holistic Approach to Reproductive Health Interventions; Talk 2 Me Case Study  
**Presenter:** Oghenefego Onome Isikiwenu, Inspiro Communications and Media

*Summary of Presentation*

This study set out to use peer educators to facilitate discussions in secondary schools on sexuality, HIV/AIDS, STIs and other Reproductive Health Issues. The project used the “Talk 2 Me” newsletter which had discussions and stories about young people as an avenue to reach out to the in and out of school youths. The presenter mentioned that an observation made on the 1,000 direct beneficiaries, there was an increase in the counseling sessions, confidence building and positive relationships among the students. Over 5,000 adolescents benefited from the newsletter indirectly. For purposes of sustainability, positive peer groups termed as “Champion’s forums” were formed to encourage and uphold the gained skills among the youths. The presenter recommends that interventions targeting young people should have components of fun and the traditional methods should be innovative and participatory in order to capture youths’ participation and interests.

**Paper 2:** Catalyzing Change: Lessons from DISHA: A program to Promote Healthy Young People in India  
**Presenter:** Sushmita Mukherjee, International Center for Research on Women (ICRW)

*Summary of Presentation*

ICRW's DISHA project aimed at delaying age at marriage and child bearing among the young people in Bihar and Jharkhand in India. According to the presenter the project intervention registered successes among the target population of young women. There was an increment in contraceptive use and age at marriage of 60 percent and 2 years from 15.9 to 17.9 years respectively. Qualitative approaches presented client satisfaction in services provided by peer educators and local private practitioner. A total of 13,304 parents were engaged in the project, while 11,791 youths, 595 youth and 69 livelihood groups were reached. Involvement of youth in identification of their local private practitioners to trained in youth friendly services increases accessibility of reproductive health services. The presenter recommends the
use of trained private practitioners in youth friendly services to scale up reproductive health services to youths. Peer outreaches are also helpful in the provision of services to youths in hard to reach areas.

**Paper 3:** Using Private Sector Funded Mass Media Campaign and NGO Alliances to Reach FP/RH Underserved Women and Youth in Guatemala  
**Presenter:** Maria Teresa Ligorria, RTI international Guatemala  
**Summary of Presentation**  
Using a national Mass Media campaign through the public private partnership, RTI designed and produced critical reproductive health messages targeting vulnerable populations of Guatemala. As a strategy, the presenter said RTI had engaged the private public sector although they did not want to be part of something that would affect their consumers due to stigma associated with reproductive health. The presenter further mentioned that the messages were meant to eradicate stigma, increase on the level of awareness and uptake of reproductive health services in the underserved population. Critical to the study, about 1 million people were reached through the mass media campaigns with 86 and 68 percent of the population able to recognize the importance of birth spacing and family planning respectively. The media contributed 100 percent through the provision of free media air time for reproductive health messages. Involvement of public private sector and for profit corporations to target the masses yields high results. The presenter recommends the use mass media campaigns since they were effective in increasing awareness of family planning and reproductive health even in traditional or conservative societies.

**Paper 4:** Giving Young Women in Kenya an Opportunity to Use Contraceptive Implants Instead of Short-Acting Methods: Preliminary Results on Acceptability  
**Presenter:** David Hubacher, Family Health International  
**Summary of Presentation**  
According to the presenter, women who seek short-acting reversible methods and those who had never used hormonal contraception as were good candidates for longer term implants. This was established by a study on 400 participants who sought for family planning services at one government in Nairobi Kenya. A third of the population had felt that the prolonged use of hormonal contraceptives would lead to future infertility; it is no wonder that some felt they needed a break from hormonal contraceptives. It was further established that the young people who had difficulty in returning to clinic for short term contraceptives were more likely use implants. The presenter revealed that the study was on-going till 2010 and that the results were yet to be confirmed. Women who have never used contraceptives are good candidate for implants. Preliminary findings also presented an increased uptake of implants and satisfaction as demonstrated by the participants.

**Paper 5:** Knowledge Perceptions and Attitudes of Refugee Youths in Oru Refugee Camp, Nigeria Towards Contraceptive Use  
**Presenter:** Kahinde Olaoaluwa Okanlawon, Obafemi Awolowo University, Ile Ife, Nigeria  
**Summary of Presentation**  
The presenter mentioned that the study employed both qualitative and quantitative methods in exploring the knowledge, perceptions and attitudes of refugee youths in Oru camp. Although almost all the respondents studied were knowledgeable about contraceptives and condom use, 3/5 were having unprotected sex. The presenter attributed this to the stigma associated with contraceptives and gender concerns as elders raised concerns “what would a 15 year old girl do with a condom”. This alone does not permit the young adolescents to access the contraceptive for fear of being associated with prostitution even when they need them. Findings present almost half of the women studied were mothers aged between 15 to 25 years. While condoms were widely available in the camp, many do not have access to other contraceptives. Most of the participants were confident about the condoms than other contraceptives due to fears associated with the side effects. The presenter recommended the need for empowering young people to reduce on their vulnerability and poverty, which causes them to go for transactional sex. There is also need to educate youths on contraceptive use as well as scale up the provision of the FP/RH services in camps.
Discussion

Questions were asked raised to the Nigerian presenter about the Oru camp, inquiring whether anyone had looked at the provision of long term methods among the youths, and if they could scale up the best practices. The presenter mentioned that there was need for social support, which had been neglected for so long. That there was need to change people’s orientation on RH/FP services especially in the Northern Nigerian where maternal health and literacy indicators were low. He further mentioned that not much was known about the use of long term methods by youths.

In addition a question was raised to all the presenters inquiring about some of the key barriers during their program implementation and how they responded to them. What were the drivers pushing them to work and curb the hindrances. According to the Guatemala experience, they had social barriers and the fact that culturally young people do not talk about RH issues. The teachers in schools did not know how to respond to questions raised by young people. So what drove RTI was basically corporate social responsibility, for 10 years some people had wanted to talk about RH/FP but they were afraid due to social stigma. As regards with the Talk 2 Me project, they experienced barriers with parents, so they invited parents to participate in the talks. As way of sustainability, the presenter of paper 1, suggested that projects in Nigeria should partner with the existing projects to scale up and avoid replication of programs.

Asked how they generated the exact numbers of 11,791 beneficiaries in the DISHA project of India, the presenter mentioned that they had strong monitoring and evaluation framework and that they had captured the names of participants for the different activities carried out. Eighty percent of the participants had been involved in one or two activities thus according to their records.

Key Recommendations

Traditional teaching methods should be scaled-up to more innovative and participatory methods to improve youth-friendly services. Problems of youths are the same across the globe, so there is need encourage the youths to use condoms other than the long term methods or hormonal methods which some are not comfortable with. The youths may have the knowledge however they need to be involved especially in program implementation to reach out their peers. The use of peer support groups and trainers is effective in reaching out to young people. There is need to involve parents and community members for social support and sustainability of behaviors changed. Young people need focused contraceptives which suit their lifestyle and the fact that many have no children yet. Most resort to the use of condoms since they do not have any contraceptives for now.

SESSION B02: CONTRACEPTIVE USE: LEVELS AND TRENDS

Moderator(s): John May, World Bank, USA; Milly Kaggwa, PACE, Uganda

Presentations

Paper 1: Contraceptive use in high risk groups of women in Ghana. (Kumasi)
Presenter: Dr. Opuka Banfour, KNUST, Ghana
Summary of Presentation
This study aimed to find the contraceptive use among women engaged in risky sexual behavior in the Kumasi metropolis of Ghana. Sexual behaviors result into unwanted pregnancies and STIs. Several studies and surveys have looked at patterns of contraceptive use among the general population, but none have considered women at increased risk of acquiring unintended pregnancies and STIs. The people who were considered in the study were those who practiced unprotected sex, multiple partners and high risk sexual partners. The criterion was those people who had vaginal sex at least 3 times a week, 2 partners, and were 18-35 years. Results showed; the mean age was 22-27 years, 89% were single, 9.5% were cohabiting, 24% had STIs and the mean sexual 3.72. In contraceptive use 96.4% had the
The use of contraceptives improved women's health, reduction of mortality and improve the general life of population. Recommendations include: strengthen community level family planning activities especially for women in rural regions whom have the highest unmet need and improve the method mix so that women get the appropriate methods for the right intentions (limiting and/or spacing).
• Intervention done by Ethiopia since 2005
• Instead of using the P. values ~ O in the Nigeria study the 95%. Confidence intervals were more informative as they provide ranges.

Recommendations

• Social marketing groups needed to be set up.
• There is need to consider the desire to have large families in Nigerian society.
• The need to strengthen the contraceptive community for FP
• Improving on the method mix in the contraceptives as a means of improving the use.

SESSION C02: PSYCHO-SOCIAL ASPECTS OF FP

Moderator(s): Anju Malhotra, ICRW, USA; Elly Mugumya, Reproductive Health, Uganda

Presentations

Presenter: Easmon Otupiri, Kwame Nkrumah University of Science and Technology-School of Medical Sciences, Ghana
Summary of Presentation
This study examined demographic characteristics associated with contraceptive use and fertility intentions, and reasons for contraceptive use and non-use. The authors conducted a cross-sectional survey with 408 women aged 15-49 in Hohoe District, Volta Region, Ghana. Data were collected from July – October, 2008. The mean age among women was 29.9 years, and nearly 59% were married. Nearly 44% of women were contraceptive users, and 25.5% were using modern methods. Women aged 20-24 years were more likely than women in other age groups to use contraceptive methods (24.6% of all contraceptive users). More than half (54.7%) of current contraceptive users were married, and more than two-thirds of modern contraceptive users were married. Nearly 75% of contraceptive users had at least one living child. More than 82% of women had discussed family planning with someone, but only 48.3% had discussed contraception with their partners. Nearly 83% of contracepting women were using injectables. More than 44% of contraceptive users wished to delay childbirth, while 24% wished to space births and 16% wished to limit childbirth. The most common reason for non-use of contraception was fear of adverse side effects (52.4%), followed by desire for children (33%). Among study participants, 37.5% did not desire more children, but more than 58% of these women were not using contraception. However, 58.5% of non-users intended to use contraception in the future. Contraceptive use was higher among this sample than the national CPR in Ghana, but more education is needed about the advantages and side effects associated with family planning use.

Paper 2: Social Determinants for Sustained Use of Family Planning (FP)
Presenter: Feven Tassew, CARE International in Ethiopia, SRH Program Unit, Ethiopia
Summary of Presentation
Using a social analysis, this study aimed to identify gaps in CARE’s family planning program in West Hararghe Region, Ethiopia. Understanding that uptake of family planning is influenced by social norms, the authors felt that important sub-groups were not adequately being served by traditional family planning services. First, community workers were trained in social analysis in action (SAA) data collection methods. Through facilitated activities, these volunteers examined their own biases in terms of contraceptive use. Volunteers then conducted a situation analysis in two sites in Eastern Hararghe. Three major barriers to contraceptive use emerged in discussions with community members. First, men and women felt that health service provision was inadequate. Individuals felt they had limited choices of contraceptive methods, and inadequate counseling on side effects. They also felt that service providers often had negative attitudes and did not reach out to marginalized groups such as men, widows, divorcees and commercial sex workers. Second, religious norms acted as a barrier to family planning use.
Because sex is only acceptable within marriage, contraceptive use was sanctioned only for married couples. Even within the context of marriage, many felt that family planning hindered the ability of God to bless families with many children. Last, cultural norms around fertility and marriage may prevent some from using contraception. Sexuality is not openly discussed, particularly not pre-marital sex. Because of taboos against extra-marital sex, adolescents, widows and commercial sex workers are among the groups that are not targeted with contraceptive services. Additionally, son preference and the need for children in the workforce are barriers to contraceptive use even within the context of marriage. These social norms must be addressed in family planning programs in order to decrease unmet contraceptive need and unintended pregnancy.

**Paper 3: Offering Socially and Culturally Acceptable FP Methods: Who Accepts and What Were They Doing Before?**

**Presenter:** Fatuma Iman, Family Health International, Kenya

**Summary of Presentation**

This research examines a pilot project introducing the standard days method (SDM) in the Ijara District of Kenya. Most people in this district are Muslim, the CPR is less than 1% and the TFR is 8.1%. The authors’ aim was to examine what happens when a socially and culturally acceptable method such as SDM is introduced in a low contraceptive prevalence area, specifically what kinds of women will accept and what methods were they using before? In 2008, the authors conducted a situation analysis by interviewing 125 community members, service providers and policy/program managers. The results of this analysis indicated that SDM would likely be an acceptable contraceptive method for this community. First, religious leaders were educated on SDM and the benefits of spacing births. The religious leaders then sensitized the community on the same topics. Next, cycle beads were provided to health facilities in the community, as well as training on SDM counseling. According to service statistics collected from health facilities between January – June, 2009, 254 women accepted the SDM method, and only 16 of these women switched to SDM from another contraceptive method. Of acceptors, 92% were Muslim, and women had, on average, 4 children. Approximately 93% of acceptors were new contraceptive users; 42% said they accepted because it had no effect on their health, while 32% said the method was not offensive to their religion. Women liked SDM because it is culturally appropriate and natural. Additionally, the cycle beads were similar to prayer beads. However, providers were concerned about future supplies of cycle beads and the time it took to counsel women on correct usage. Non-users of family planning were attracted to the SDM in this community. Therefore, it may be a culturally appropriate method in conservative, low contraceptive prevalence areas.

**Paper 4: Variations in Unmet Need for Contraception over the Lifecourse**

**Presenter:** Susan M. Lee-Rife, International Center for Research on Women

**Summary of Presentation**

This study utilized longitudinal data to examine unmet contraceptive need over the lifecourse. In particular, the authors aimed to understand how unmet need varies over a woman’s lifetime. They also aimed to estimate the percentage of intervals between births in which women experience unmet need. Because previous experiences with unmet need may predict present or future experiences, cross-sectional unmet need measurements may not provide enough information to illustrate the breadth of the problem. The study was conducted with 2,444 married women in Madhya Pradesh, India, who provided 11,160 intervals between marriage and first birth or between births for analysis. Nearly 51% of women had experienced unmet need for contraception in at least one interval. The percentage of intervals characterized by unmet need decreased with age, with 50% of intervals at age <20 years characterized by unmet need versus 33% of intervals at age 35-39 years. There was not much variation in unmet need by level of education. The lifetime burden of unmet need is much higher than cross-sectional estimates, and cumulative measures of unmet need may present a more accurate picture of the need for contraceptive services.

**Paper 5: Effects of economic status and family planning ideation on married women’s fertility intentions in Ghana and Kenya.**

**Presenter:** Agbessi Amouzou, Johns Hopkins Bloomberg School of Public Health
Summary of Presentation
Using Demographic and Health Survey data from Ghana and Kenya, this study examined the net effects of economic status and family planning ideation on married women’s fertility intentions. Data came from the 2003 DHS surveys and included 2,720 women from Ghana and 3,681 women from Kenya. All subjects were women in union with at least 2 children. Multinomial logistic regression models were fitted to examine variables associated with fertility intentions. The dependent variable was categorical: wanting no more children, wanting to delay childbearing for at least two years and wanting another child soon. Main independent variables were an asset index and an ideation index composed of family planning knowledge and attitudes, ideal family size and visits by home health workers. The analyses also controlled for education, residence and parity. 47% of women in Ghana and 60% of women in Kenya wanted no more children. In the fully adjusted models, ideation was strongly associated with intention to limit or delay childbearing. This association was strongest in Kenya, where women in the highest ideation quintile were 10 times more likely to desire to limit childbearing and 3 times more likely to desire to delay childbearing than those in the lowest quintile. After adjusting for other variables, wealth was not significantly associated with fertility intentions in Ghana. However, ideation mediated the association between wealth and fertility intentions in Kenya. In the adjusted model, the wealthiest women were 70% less likely to desire to limit or delay childbearing compared to the poorest women. Changing ideation is a powerful tool for generating demand for family planning, even among the poorest women.

Discussion
One audience member asked Agbessi Amazou if he did further analysis to examine which components of the ideation were the most important predictors in his models. He replied that he had not done that with these data, but that each item has been shown to be individually associated with fertility intentions in the literature.

Another audience member asked the presenter from CARE if they were able to successfully change community providers’ attitudes toward family planning with the intervention. She replied that, though the intervention just started last year, providers were starting to acknowledge their own biases and were appreciative of the tools to challenge their attitudes. They are presently reflecting on these biases every quarter and have developed indicators to measure change.

Another audience member asked Fatuma Iman from FHI about compliance to the SDM, especially within marriage. She said they had not done any formal studies, but the clinic reports suggest most clients abstain on their fertile days. Others use condoms, even in very conservative settings.

Someone from the audience asked Susan Lee-Rife from ICRW about how many women in the India study equated family planning with sterilization. She also asked if the study had generated any thoughts about messaging in terms of using “birth spacing” versus “limiting,” but that the Indian government needs to focus on raising awareness of methods for birth spacing.

In reference to the SDM study, an audience member commented that natural methods have a high failure rate. She wanted to know if the failure rate was measured in the study. The presenter replied that effectiveness rates have been found as high as 95% for 13 cycles in other countries. So far, there have been no complaints about women getting pregnant using cycle beads in this study.

Another audience member asked Fatuma Iman about the method used to evaluate fertile days among SDM clients. In reply, the presenter commented that 95% of women were literate and that the menstrual cycle was explained to them as an approximately one month interval.

Last, in reference to the study from CARE-Ethiopia, one of the session moderators pointed out that the taboo topics of pre-marital sex and commercial sex work were big problems. Without serving these populations, aren’t we leaving out a huge part of the population, especially in urban areas? The presenter replied that, because these are socially taboo topics, they are “blind spots” for family planning programs.
The main challenge is how to reach these hidden groups. The CARE intervention is aiming to facilitate continuous discussion about these topics among community support groups, with a particular focus on community leaders.

**Key Recommendations**

Social and religious norms are important predictors of family planning demand and use. These should be focal points of any contraceptive program. Religious and fertility norms may marginalize certain groups from receiving adequate family planning services. These groups should be targeted through specialized programs. Programs should also focus on gender issues such as son preference and men's roles in family planning. Project staff and family planning providers need to be confronted with their own biases in family planning programs. Traditional and religious leaders should act as gateways to the community for family planning programs. For advocacy purposes, unmet need should be quantified over the life course, like burden of disease in epidemiology.

**SESSION D02: INTEGRATING FP AND HIV PROGRAMS II**

**Moderator(s):** Bocar Diallo, IPPF, Kenya; Fredrick E. Makumbi, Makerere University School of Public Health, Uganda

**Presentations**

**Paper 1:** Addressing the Family Planning Needs of People Living with HIV and AIDS Through Integration of Family Planning Services at an ART Center in Uganda  
**Presenter:** Grace Nagendi, Engender Health, Uganda  
**Summary of Presentation**  
High levels of unmet need and unintended pregnancies characterize reproductive health among HIV+ individuals in Uganda, but it is not clear to what extent HIV and FP services should be integrated. ACQUIRE piloted a program to integrate FP into HIV care and treatment services at TASO/Mbale ART center in Eastern Uganda. Investigators performed a needs assessment to before designing the integration, and then evaluated the integration program through in-depth client interviews, focus groups discussions, and client-provider observations. ACQUIRE also assisted with a media campaign to raise awareness. FP was provided to 605 clients, who were generally happy with the FP services, and did not feel that it had a negative impact on HIV care. Providers respected the SRH rights of clients. The presenter described stories of advocates that demonstrated the successes of the program. Challenges included record keeping forms which did not accommodate family planning, problematic referral of clients for long-acting methods, contraceptive stock outs, and rumors and myths about FP in the community.

**Paper 2:** Demand for Family Planning Among Women VCT Clients: The Need for Integration, Dessie Town, Northeast Ethiopia  
**Presenter:** Dessalew Emaway Altaye, Engender Health, Ethiopia  
**Summary of Presentation**  
Researchers in Ethiopia set out to investigate the demand for FP among women VCT clients, and to assess to what extent the VCT centers are responding to FP needs of their clients. 422 female VCT clients participated in a facility-based cross-sectional study in Dessie Town, which collected quantitative and qualitative data. In this population, 16% of women were HIV-infected. Young women were more likely to have unmet need for contraception, but serostatus did not appear to affect levels of unmet need. HIV-infected clients were more likely to reporting intentions to avoid childbearing in the future than HIV-uninfected women, but still a considerable percentage of HIV+ women intended to have a child in the future. NGOs seemed to perform better in terms of informing VCT clients on FP, than did clinics publically or privately owned. While integration received high approval among clients and providers, the may increase staff burden, and integration will require logistical and service rearrangements. No explicit strategies or guidelines exist detailing how best to integrate FP and VCT.
Paper 3: Service Delivery Characteristics Associated with Contraceptive Use Among Youth Clients in Voluntary Counseling and HIV Testing Clinics with Integrated Family Planning Services

Presenter: Joy Noel Baumgartner, FHI, United States

Summary of Presentation

A descriptive cross-sectional and cohort study in Kenya examined characteristics of facilities, available services, providers and clients across a variety of FP/HIV integrated clinics that serve youth, and to assess which modifiable factors were associated with FP uptake and continuation in youth. 20 facilities were randomly selected, including 8 specifically “youth-friendly” sites, and 12 general sites. 84% of clients had no desire for children in the next three months – but although 72% of respondents were currently sexually active, only 26% were using a modern FP method. Only 30% of providers were ever trained in FP/HIV integration. Client factors associated with same day FP uptake included: having a partner (either live in or not), higher education, higher number of children, no desire for children soon. There was little evidence that most provider or clinic factors were associated either with same day FP uptake or intention to use, or with FP use 3 months later, which may reflect suboptimal integrated services.

Paper 4: The Need for Reproductive Health Services Among HIV-Positive Women in Zimbabwe

Presenter: Lorrie Gavin, CDC

Summary of Presentation

We need to understand reproductive desires of HIV+ women, the effects of ART on these desires, and how to reduce barriers to contraceptive use. However, existing research on these topics often includes unrepresentative samples and seldom include a comparison group of HIV- women. Furthermore, exploration of psychosocial variables influencing desire for pregnancy has been limited. Using DHS 2005-06 data on 5159 Zimbabwean women, this study compared fertility intentions by serostatus, assessed factors associated with desire for children, and how serostatus interacts with other factors to influence this desire. Investigators found that HIV+ women were about half as likely to want a child in adjusted analyses, and that intentions were also associated with age, education, marital status, and parity. Variables that were not significantly associated with fertility desires included HIV testing, risk perception, and knowledge of MTCT or ART. Two statistical interactions were found: HIV+ women in rural areas were more likely to desire pregnancy than HIV+ women in urban areas, and richer HIV negative women were less likely to want a future pregnancy than poorer HIV negative women, whereas SES was not significant in HIV+ women. Regardless of serostatus, proportions of sexually active women who don’t desire pregnancy but are not using contraception were similar.

Paper 5: Increasing Support for Family Planning as HIV Prevention: Identification of Influential Individuals and Stakeholder Perceptions

Presenter: Tricia Petruney, FHI

Summary of Presentation

Preventing unintended pregnancy in HIV+ women is part of the WHO strategy to reduce perinatal HIV, but this strategy is largely ignored, potentially due to restrictions on time or money, territoriality or friction, and lack of information or evidence. The project described aimed to identify influential individuals in international the HIV/AIDS field (globally and in a 2nd phase, in Andhra Pradesh, India), to determine barriers to supporting or implementing strategies or factors that could facilitate adoption of this strategy, and to reach influential individuals with targeted advocacy. Respondents seemed to focus on barriers to increasing support for this strategy, rather than elements that could facilitate the process. They cited a complex array of challenges, with the two most frequently cited being a lack of funding and a lack of infrastructure or capacity to link services. One prominent donor noted that for some, HIV services are narrowly defined and FP is not seen as part of their responsibilities.

Discussion

An FHI representative wondered if TASO has continued work and expanded its pilot program to other sites, and Grace Nagendi noted that it has expanded to all other centers country-wide. They are using the same staff members, but training them more.
Concerns were expressed about offering FP in VCT centers, since people may come only once, which may not provide an appropriate setting for follow up care. Dessalew Emaway Altaye responded that VCT providers can still offer FP information, referrals and counseling.

Audience members questions Dr. Gavin about the model used to understand fertility intentions and serostatus; specifically asking whether partner HIV status or treatment had an effect on fertility desire, and whether knowledge about PMTCT was assessed. Dr. Gavin responded by saying that partner status was self-reported by women, which gave rise to doubts about validity. They also had a small number of women on ART, so they did not consider it. Surprisingly, four questions used to assess knowledge about PMTCT were not associated with fertility intentions.

Tricia Petruney agreed with audience members that there is a lack of coordination globally and nationally for promoting FP in HIV+ women. Individuals interviewed for the project seemed to take ownership for the failures instead of blaming the other side, but nobody seemed to step up as a champion. One positive improvement is the increasing number of national and international technical working groups for this issue. Other audience members were concerned that HIV care might be compromised as services are integrated; but studies show that the addition of FP in VCT don’t have a negative effect on VCT services.

**Key Recommendations**

Integration of FP and HIV care was acceptable and feasible in several sites reported on, including Uganda and Ethiopia. Clients who experienced a pilot integration program in Uganda were pleased with the results, and did not feel that had a negative impact on HIV care. Integration is difficult since there are no explicit strategies or guidelines that detail how best to integrate FP and VCT. Although comparatively lower than HIV-uninfected women, HIV-infected women still report considerable levels of desire to have a child in the future, and their SRH rights must be respected. Fertility intentions among HIV+ women are associated with age, education, marital status, parity, and place residence. A Kenyan study of FP uptake in FP/HIV integrated settings suggested that uptake was more associated with client factors than with provider or clinic factors, which may reflect suboptimal integration. We need to ensure that integration programs are effective so as not to miss opportunities to provide FP services in this population. Interviews of influential individuals in HIV/AIDS revealed barriers to adopting the strategy of FP for HIV+ women as a strategy for perinatal HIV reduction. We need strengthened education around this issue, as well as research efforts and fundamental changes in funding mechanisms and policy structures. FP/HIV integration must be prioritized.

**SESSION E02: CONTRACEPTIVE TECHNOLOGY II**

*Moderator(s):* Paul Blumenthal, Population Services International, USA; Bitra George, Family Health International, India

**Presentations**

**Paper 1:** Fertility Awareness-based Methods and Gender  
*Presenter:* Irit Sinai, Georgetown University, United States of America

*Summary of Presentation*

In this study, Sinai and Bijou investigated the relationship between Fertility Awareness-based Methods (FAM) and gender. They specifically highlight the contribution that integrating FAM into family planning (FP) services makes in promoting gender equity (fairness and justice), and particularly in empowering women. The presenter emphasized a key point, that promoting gender equality and empowering women is one of the Millennium Development Goals. Several similar studies done were used to get data to determine this relationship between integrating FAM into FP services and promotion of gender equity. In this study, gender equity is seen as being promoted through increasing a woman’s control of her fertility, her knowledge and improving partner communication and co-operation. Regarding communication, the presenter stated that these methods require communication, as the men need to know that a woman identifies a day as fertile. On the other hand for cooperation, the couple needs to agree as one, not to
have unprotected sex during the woman’s fertile days. The presenter explained that data from previous studies of users of two types of FAM (Standard Days Method and Two Day Method) was examined to explore effect of FAM on gender equity. Using FAM greatly promotes Gender equity through improvements in couple communication and cooperation. The couple makes a decision together and agree to stick to these decisions, fostering prolonged communication and cooperation tendencies even in matters outside FP. Notably in India, 93% of women reported increased communication and ability to discuss sex with their husbands. Implying partner participation was high. FAM does promote gender equity and increases women empowerment, as they have a say in and control over their own fertility and this subsequently expands choice in FP.

**Paper 2: Increasing Access by Introducing a Low-Cost Contraceptive Implant in Resource Constrained Countries**

**Presenter:** Dr. Marcus Steiner, Family Health International, United States of America

**Summary of Presentation**

This study stemmed from the fact that though they are highly effective and a safe contraceptive method, the high cost of implants has been a major set back in assuring their availability and sustainability in many countries, especially resource constrained countries. The goal was therefore to establish a partnership between global public and private sectors and NGOs to ensure that people especially in resource constrained countries have access to high quality and affordable contraceptive implants. Research studies show a global estimate of 1.8 million unplanned pregnancies, 576 abortions and 10,000 maternal deaths. The presenter stressed that this study is just about moving from an effective to a highly effective method. Many countries like Ethiopia, South Africa and Uganda among others are experiencing increase in implant use. The three major types are Sino implant which can be used for over 4 years, Jadelle for over 5 years and Implanon for 3 years. Sino is 60% less expensive that Jadelle and Implanon. Service delivery is easier for Sino and Jadelle as compared to Implanon because the trocars of the first two are disposable and in addition Jadelle can be autoclaved. Shanghai Dahua Pharmaceuticals manufactures Sino-implant (II). Over 15 studies done have proved that Sino is safe and effective and over 22,000 women are using it for up to 7 years, with an annual pregnancy rate of less than one percent. The presenter highlighted the issue of quality assurance, and explained that Family Health International has testing facilities in the US and Thailand to ensure distribution of high quality public health commodities. Findings were from the 3 key areas of coordinating successful introduction and scale-up activities, facilitating regulatory approval in resource constrained countries and monitoring the production quality of Sino-implant (II). Sino-implants realize substantial cost savings for both governments and donors (Orders in the first 4 months of 2009 achieved an estimated cost savings of US $1.4 million). The presenter pointed out that Sino-implant should be introduced in a well-coordinated manner into other programs. Some of the strategies for successful scale up activities include; training/trained providers, adequate pre-counseling, reliable access to services, appropriate supervision and evaluation.

**Paper 3: Three Female Condoms: Which One So South African Women Prefer?**

**Presenter:** Dr. Carol Joanis, Family Health International, United States of America

**Summary of Presentation**

The presenter stated that there are 7 devices going around currently in South Africa, however only 3 were chosen for this study as they are the common ones and are going through a regulatory process. Donors and South Africa’s Ministry of Health alike have been concerned with which one to purchase or recommend. To answer this question, the researcher and others conducted a study on preference among 3 female condoms. This study sought to determine safety, acceptability and functional performance of each device. First is the PATH woman’s condom which is polyurethane, self lubricating, has insertion capsule and film retention pads but it is an investigational device and PATH will seek approval from China in 2010 and European Union (EU) in 2011-2012. Second is the FC2 (Female Health Company) with synthetic latex and inner ring, is also on the WHO list and approved by EU. Third and last is the V-Amour (Med tech limited) also with latex, v-shaped frame, pre-lubricated and approved by EU. The presenter then explained that the study was designed to try and answer this question of "which condom is preferred", in different ways. A real world application was used in this case with part one of the methodology being a randomized prospective cross over trial, part two in a simulated market and part three was qualitative (in-depth interviews). Of the 170 women in part one 160 used all 3 devices and of
the 148 women in part two, 132 used all 3 condom types. Respondents were all and had to be literate as coital diaries were used. Findings revealed that 85% of respondents had never used a condom, which the presenter found quite interesting and clearly PATH and FC2 in the randomized trial are greatly preferred. A bit of shift was seen in market simulation, with preference for PATH going down and that for V-Amour going up. Joannis et al found absolutely no difference in these 3 devices, which results were consistent with other studies done. All women preferred one of the condom types. The presenter emphasized an important take home message to the audience, which was that there is very little or no significant difference between the 3 devices. All were frequently used and reliable, with little or no complaints of side effects.

**Paper 4: Pattern of Vaginitis among Intra-uterine Contraceptive Device Users in Ibadan, South-Western Nigeria**

**Presenter:** Stella-Maris Ngozi Okonkwo, University College Hospital, Nigeria

**Summary of Presentation**
Numerous studies have shown that the Intra-uterine Contraceptive Device (IUCD) is the most common method chosen by women worldwide. Similarly in Nigeria it is the most commonly preferred method. The presenter stated that IUCD is associated with vaginal discharge and there is a 2.09 relative risk of abnormal vaginal discharge in users of IUCD as compared to non-users. The aetiology varies from family planning (FP) centre to FP centre and the significance of IUCD and Vaginitis is not clear. However it is clearly documented that when persistent, Vaginitis disturbs many women and so is a ground for discontinuance of IUD use. In this descriptive cross sectional study among a cohort of IUCD users with Vaginitis at a FP clinic, results showed that most women had used IUCD for at least 3 years. The respondents were all married and the majority were educated. 100 of them complained of vaginal discharge, 25% had scheduled visits as compared to 75% who had unscheduled visits to the FP clinic. According to the presenter, this suggests that Vaginitis among IUCD users is a major public health issue of concern and a problem among women of Nigeria. The etiology of Vaginitis among IUCD users was found to be majorly bacterial. However there was considerable loss to follow up of some of the respondents during the study. Women who used IUCD for less than 4 years were 1.29 times more likely to have bacterial vaginosis and those with low education status were more likely to present with candidiasis. Age above 40 years among IUCD users is associated with an increased risk of vaginal candidiasis, though this was not statistically significant. As a standard of care for IUCD users especially in developing countries, periodical empirical treatment for candidiasis and bacterial vaginosis with anti-fungals and oral metronidazole is applied.

**Paper 5: Expanding Contraceptive Options through Incremental Improvement in Existing Technology and Developing Totally New Methods**

**Presenter:** Dr. Jeff Spieler, USAID, United States of America

**Summary of Presentation**
The presenter began by stressing that existing contraceptive methods have played and still play an extensive role in reducing Total Fertility Rate and maternal mortality by preventing unintended pregnancies. And that new technologies in contraceptive methods also have an important role in providing and expanding options to the users. With the current greater unmet need than met need, there is need for all of us to make sure that there is a choice, as some women even with comprehensive provider counseling about a particular method may still prefer some methods to others. Even with education, training/knowledge on a particular method, may still not want to use it. The presenter in his study hypothesized that relatively high rates of discontinuation of some current methods can be partly resolved with better and new contraceptive methods. The unique thing about levonorgestrol intra-uterine system as a method is that it "marries" or combines benefits of both oral contraceptives and intra-uterine devices (IUD). The presenter then posed a question “What are the health benefits of contraceptive methods on contraception?”. According to him, the answer to this question will readily change the idea on contraception. For instance, if you are anaemic, levonorgestrol is better than IUD. The thing that was not highlighted in the presentation, that the presenter wanted the audience to know was that levonorgestrol is the only long acting hormonal method that is in the control of the woman, as she can choose to cease usage whenever she pleases. The presenter also in his view thought that a device like this would last for about 5 years. However the disadvantage of the female condom is that a woman has to use additional
lubrication. Currently the four options for men are condoms, vasectomy, withdrawal and fertility awareness campaigns. Although a lot has been done to understand male contraception, hypothetical studies though done were not very valuable, as they did not highlight which particular method was mostly preferred. The presenter in his view stated that the 3 most important things in contraceptive use are getting out the existing method/making it known, taking the existing method and making them better and developing new technologies that are really needed by the people (male/female). As an illustration in his conclusion, the presenter singled out a study done among sex workers in Ethiopia to illustrate why the use of certain contraceptive methods. Results showed that women who were using condoms to prevent pregnancy, 54% would not have unprotected sex as compared to 10%. Dual protection in this case would be a game changer.

Discussion

The fourth presentation on pattern of Vaginitis among IUCD users in Nigeria attracted many of the questions and comments during this session. Clarity was sought by the few members of the audience on the prevalence of bacterial vaginosis in the sexually active non-IUCD users. The presenter's response focused on the findings of the study and previous studies that the high incidence of bacterial vaginosis is in IUCD users and more importantly bacterial vaginosis and HIV/AIDS have been linked. The presenter highlighted that given three quarters of visits by the women to the clinics were unscheduled, this should be seen as a positive thing. Many of the women and particularly the IUCD users would have many of their problems identified and addressed/managed.

Still on paper 4, the moderator stated that the presenter had a big confidence interval but was not statistically significant. Cautioning that researchers must be careful with statistics and how they interprete and present their results. That to prove the negative is much more difficult than proving the positive.

Responding to the concern about the use of surgical sterilization in this among the women, the presenter of the 3rd paper made it clear to the audience that this was one of the reliable methods in the inclusion criteria. The presenter also added that this was not an efficacy study and was in a non-significant population. One reason to use this method is that you worry about who you are having sexual intercourse with, which also contributes to a reduction in risk of HIV/AIDS and STIs.

There was also a discussion on the question raised for the 1st presentation by a member of the audience about how to reconcile counseling with dual protection. The presenter stated that contraceptive users receive a lot of comprehensive provider counseling that is meant to impart knowledge and information on contraceptive use and in this case dual protection. One of the best options is to use condoms with other methods, part of counseling is to point out that a particular method solely will or will not entirely protect one from HIV/AIDS as it will unwanted/unintended pregnancies. The moderator emphasized that unless dual protection can be got, then many providers of sexual and reproductive health services will be stuck. A contentious issue about the church and its condemning sexual pleasure as they view sex as for only procreation was raised by a member in the audience. However no specific response was given to this concern.

The moderator commended the offering Fertility Awareness-based Methods increasing knowledge of women about FP and other reproductive health issues and their control of fertility. this increases women’s empowerment and also expands on their FP choices.

Key Recommendations

There in minimal interest in IUD as compared to implants, despite its studied effectiveness as a contraceptive method. Yet since there is tremendous unmet need, IUD requests and places are up of which 80% are post placental. IUDs are a globally huge untapped market. More research on IUDs and training of women and service providers on IUDs need priority and undertaking, to bring to light this contraceptive method. Sino-implant (ii) as a low cost contraceptive implant should be introduced in national FP programs in a well-coordinated manner. This was deemed by a gender and health specialist
in the audience to substantially lead to cost savings for governments and donors alike. Basing on the 5th presentation, there is need for research on implants as they have not been comprehensively looked at for many years. Governments should partner with concerned national and international organizations to expand contraceptive technologies and also develop new methods, as a way of expanding user choice. There is need for the service providers to make sure that there is choice, as some women may prefer some methods to others.

SESSION F02: PROMOTING FAMILY PLANNING THROUGH DIGITAL, MOBILE, AND WIRELESS TECHNOLOGIES

**Moderator(s):** Julie Wiltshire, Straight Talk Foundation, Uganda

**Presentations**

**Presentation 1:** Mobile and Wireless Technologies in Support of Family Planning Programs: Present and Future Solutions for Faster Reporting without Sacrificing Data Quality  
**Presenter:** David Charles Cantor, ICF Macro

**Summary of Presentation**

There are several mHealth technologies that can be used for remote data collection. mHealth stands for “mobile technology for health.” Those that are used for remote data collection are: 1) GSM, or Global System for Mobile communication, which is found throughout Africa; 2) SMS and MMS, or better known as text-messaging; 3) GPRS, or General Packet Radio Service (3G), which has more applicability to surveys and is able to collect data for timely reporting; and 4) GPS, or Global Positioning System, which allows people to pinpoint their precise location on the earth. A survey of telecom growth across the world shows that mobile phone usage is increasing exponentially while growth of fixed telephone lines is flat. Most of this growth is taking place in developing countries, exponentially compared to the developed world, where it is growing linearly. Furthermore, the cost of connectivity is decreasing, especially in the past 2 years. (For example, in Ethiopia, a cellphone subscription costs about $20). There have been millions of new mobile phone subscriptions in a year; and mobile operators are investing $50 B in SSA in the next 5 years. In 5-10 years, it is projected that there will be universal 3G coverage.

One example of mHealth in action was the usage of PDAs for mobile data collection in Albania in 2004. In this example, mHealth saved time and money (cost-benefit analysis showed positive results) and resulted in better quality data. Although in this example information was collected in the field (in not very far or remote areas) and physically brought back to headquarters, data entry programs can also send information wirelessly. Therefore the missing component here is telecommunications, or the connectivity component. Data can be sent back to HQ and look at it in real time. This has implications for routine reporting, stockouts, coldchain monitoring—things that are very time sensitive.

**Presentation 2:** Family Planning via Mobile Phones: Proof-of-Concept Testing  
**Presenter:** Katherine Lavoie, Georgetown University

**Summary of Presentation**

CycleTel is a mHealth solution for the Standard Days Method where a woman can send the date of her menses to the program and then she will receive texts about her fertility status at a predetermined interval (for example, every day or only on her fertile days). The Institute for Reproductive Health (IRH) is testing this in India, where there are 350 million subscribers in rural and urban areas. Currently, IRH is in the process of doing “value of proof of concept” testing, or confirming interest in the program among the target population now, Uttar Pradesh. The research design has three phases of which the first phase (focus group discussions with 54 participants) has been completed. The next step will be to conduct cognitive interviews and conduct manual testing with about 30 couples.

Focus group discussions found that all participants owned a phone and expressed a need for family planning. There was a need and demand for family planning as well as a simple information method. Strong interest was identified among both men and women for the program, but there is widespread lack of knowledge about fertile days. Participants preferred messages given in specific, concise language and
in a form to protect privacy. They stated that messages should be sent out in Hinglish, where Hindi words are spelled in the Roman alphabet. Participants also expressed that the term “fertile day” was seemed degrading to women, but only in this context. Researchers found it surprising that males were interested in this program. Half of the males thought that both partners should receive the messages, which is important because Cyclebeads cannot be used by the women alone. Males need to be involved and this finding is transferable to the mobile phones. Also, people were willing to pay to this service.

Lessons for mHealth beyond this project are that confidentiality is an issue, even when cell phones are individually owned. Language of the text is important as well as the frequency of messages and precise wording is important. Furthermore, the mHealth solution must address a definite local need.

Presentation 3: Toll-Free Hotline Spreads Information on Family Planning Services Throughout the DRC
Presenter: Jamaica Corker, Population Services International, DRC

Summary of Presentation
DRC’s size and topography presents a particular challenge for health programming. It has only 3000 km of paved road through thick forests, so traditional information, education, and communication tactics are difficult or even impossible to implement. It is a post-conflict country and there are still small conflicts that can make it difficult to implement stable programming. Furthermore, there are no reliable statistics and programs must base their programs on estimates. It is estimated that there are 3 million women with an unmet need for family planning. The hotline, Ligne Verte, was established by PSI in 2005. Ligne Verte was prepaid for the calls it received and was the first of its kind in the country. Ligne Verte guaranteed trained providers, information and products. Cell phones in DRC are growing, but it is still a fairly new technology. As of 2007, only 10% of Congolese were cell phone subscribers and only 50% lived within network range. However, since cell phones are often shared, access may actually be more than what the numbers represent.

Community mobilizers who answer the phone must be able to speak three languages. These volunteers collect information on the call, and all information is entered by hand and analyzed weekly and monthly. Callers are referred to partners clinics run by Confiance, but if these are not available in the caller’s area, then callers are referred to local clinics (but then PSI cannot guarantee if family planning services or products will be available).

Ligne Verte is promoted through commercials, interviews with family planning clients, pocket calendar distribution in IEC and CCC events, and through word of mouth—which is the biggest way since most of the country is not covered by TV or radio.

An overview of 2008 call data was given. Data are aggregated by location (PSI cannot correlate calls with population size or demand for services). Although the hotline was originally planned for women, but 80% of calls are from men. (This data is consistent with a similar CDC-HIV project in DRC, as well as similar projects in Benin and Pakistan. The reason why is unknown). Questions asked by callers are usually general, for example: what is family planning, what is birth spacing, what is the Pill, etc. At the same time, many men call for their female partners, like about side effects of contraceptive methods. PSI found that some callers came from provinces where PSI/ASI have no family planning services. Periodic increases and decreases in call volume was linked with phone company coverage.

Presentation 4: Digital Portraits of Changing Rural Masculinity in South Africa: Engaging Men in Family Planning and HIV Prevention Producing and Sharing Personal Stories
Presenter: Amy Lenita Hill, Center for Digital Storytelling, Silence Speaks Initiative

Summary of Presentation
The project is based on premise that everyday stories by men can help change behaviors, community norms, and institutional policies and practices. Local voices are central in promoting new images of masculinity and help combat negative portrayals of men in mainstream media. The project also produces short digital videos to be shared with other media and partners in order to fill a gap in the lack of available information available in the local languages, especially in rural areas. Silence Speaks was a collaborative effort carried out for the past 10 years with South Africa’s Sonke Gender Justice Network. The project led
5 workshops with adults and young people in 3 provinces in RSA. The workshops brought small groups of participants together to share stories in a group, record voiceover narrative, collect or develop photos and/or video clips to illustrate the stories. They then learned how to edit those materials into final digital materials. Workshops were tailored to participants since there are differing levels of access to technology and participants’ interest in developing these skills, etc.

The finalized personal narratives and videos were shared as part of rural education and policy activities by Action Teams. Videos were also shared on local community radio stations. Since they’re compact, they’re very effective tools. Lessons learned from the project include: digital storytelling on family planning matters in an international context is useful, especially in environments where material and health needs are urgent; who benefits from the media and who gets to participate need to be addressed; ethical issues of capturing participants’ stories while respecting their rights must be addressed as well as ethical implications of how, when, and where to share these personal narratives.

Presentation 5: RH Interchange: An Online Tool to Support and Analyze Contraceptive Commodity Funding at the Global, Regional, and National Levels, 2004-2008
Presenter: Joy Kamunyori, John Snow, Inc.

Summary of Presentation
Reproductive Health Interchange (RH Interchange) is a website tool for contraceptive delivery for global stakeholders and can be used for advocacy, resource mobilization, decision-making, and coordination. RH Interchange is the only website that regularly updates and tracks contraceptive shipments and orders. RH Interchange tracks 75% of donor funding for contraceptive supplies over the past 3 years.

The website is available in 3 languages and can generate a wide range of reports to assist with contraceptive procurement and delivery, for example: Whether the amount of contraceptives being procured meets global needs; How much money do donors and countries need to budget to meet their country’s needs; Proportion slide: can be used for advocacy, program budgeting, donor coordination; Whether the contraceptives that donors provide are a good reflection of donor priorities; and Who is funding contraceptives in a specific country. The reports can be seen by year, funding source, method, country, etc. and RH Interchange can create graphs for illustrative presentation.

Discussion

Participants expressed concern about the quality of data entry when using small devices in mHealth programs, and the specificity of the training needed might be a limiting factor in usage of these devices. Mr. Cantor explained that the software that he has used in the past can do range skips and consistency checks at the point of interview, so it cuts down on errors from using paper questionnaires where the interviewer goes to the wrong question or follows the wrong paper trail. Furthermore, the devices can be programmed that the correct question comes up depending on the input into the previous question. The presence of a telecommunication network where data can be transmitted in real time also eliminates the step of bringing the questionnaire back to the data entry site, coding the data and reentering it. Therefore, this can be looked as data quality improvement. However, Mr. Cantor pointed out that portable devices may be useful for a short questionnaire but may cause fatigue with longer questionnaires.

With regard to text messaging reminders about fertile days, an audience member pointed out that more market research should be done on sharing of cell phones and whether a program is appropriate in a certain area because privacy and confidentiality is a concern.

SESSION A03: REACHING YOUTH: CONTRACEPTIVE ACCESS AND USE

Moderator(s): Eliya Zulu; Laurie Zabin, Johns Hopkins Bloomberg School of Public Health
Presentations

Presentation 1: Predictors of Contraceptive Use among Young Women in Urban Northern Nigeria
Presenter: Mu’awiyah Sufiyan, Johns Hopkins Center for Communication Programs

Summary of Presentation
Contraceptive use is low in Nigeria according to the 2003 DHS. Increasing modern contraceptive use requires evidence-based strategies that focus on predictors of contraceptive use. This study aimed to assess the social demographic and psychosocial factors that significantly affect contraceptive use amongst sexually experienced urban girls. Findings show that 14% of sexually experienced young women are currently using modern FP and this use is lower among the married women than their never-married counterparts. Positive predictors of contraceptive use included perceived social approval, awareness about contraception method, perceived self-efficacy to obtain contraceptive methods and discussion about FP with significant others.

Presentation 2: Changing dynamics of contraceptive use among young adults in India
Presenter: Usha Ram from International Institute for Population Sciences

Presentation Summary
The presenter noted that preliminary analysis of latest contraceptive use dynamics data for India indicated a wider penetration of both reach and acceptability of family planning (FP) services compared to the past, and yet its access and/or promotion among young adults is very limited. The study hypothesized that with increased awareness, demand and access, use of contraception among young adults should increase. The study found that less than 16% of married women aged 15-24 used contraception in 1992-93. For 2005-06, 27% of them reported using any contraception. Among the states with high HIV prevalence, condom use among married young adolescents has not changed much over past 15 years and in fact it has slightly declined. Lessons learned: there is an increase in demand for contraception among married young adults.

Presentation 3: Peer Educators and School Support: We Need Education and Teachers to Support our Work on ASRH Arena
Presenter: Regina Benevides from Pathfinder International, Mozambique

Presentation Summary
The presenter stated that before the school-based initiative of the program is handed over to the MoH, a complete assessment of current programs was carried out. The aim was to find out which changes should be made to the program if any, what standards should be applied to GB schools, and how effective are the programs strategies in improving adolescent knowledge and RH behavior and attitudes. Findings were that leadership was a proxy for stronger performance i.e. if the director of the school was fully involved in program then this was a proxy for stronger performance. Also the activists’ knowledge was a good indicator for strong performance. In schools were activists’ knowledge was weak, there are potentially more negative effects of the program, especially if leadership is also weak. Lastly, it was noted that knowledge of the school director was critical to having a school perform strongly.

Presentation 4: Improving Contraceptive Access and Use among the Youth in Lungwena and Makanjira Areas in Rural Malawi.
Presenter: Andrew Ngwira University of Malawi

Presentation Summary
The presenter noted that Malawi recognizes that the health of young people is a priority and that CPR among young people is low. The main problem was the limited access to sexual and reproductive health (SRH) services at the health facilities and also the many myths and misconceptions among youth. In Malawi there are strong cultural values and initiation ceremonies that lead to early marriages and pregnancies, which increases the risk of getting HIV, the presenter said. The program set up messages on condoms and FP through dramas and also trained youth in school and out of school on community distribution of modern family planning methods (YCBD) including customer care, counseling and confidentiality. The results showed that access to family planning at community and facility levels rose to 28% in 2006 from 12% in 2000. There was improved availability of contraceptive method mix, improved sources of methods, ready access to FP e.g. during breaks in football matches and increased interaction
and debate on modern FP. The use of community structures enhanced acceptability of modern FP, there was increased involvement and participation of youth and increased demand for FP.

**Presentation 5: Assessment of the Straight Talk Foundation (STF) Peer Education Approach to Sex Education in Arua and Bugiri Districts in Uganda**

**Presenter:** Jeralom Omach, Straight Talk Foundation, Uganda.

**Presentation Summary**

The presenter said that STF has an ecological model that works with adolescents but also works with parents who may determine how the adolescent behaves and also works with community leaders. A program (in Bugiri and Arua) to target p.5 to p.6 children aged 10-14 using plays, games and sports was started. It was hoped that the program would empower the young girls to manage problems they encounter, to enhance child-child learning and to encourage children to develop open and positive attitudes towards FP. The presenter reported that much of problems encountered in Africa are due to late entry into reproductive health education. 50 primary schools and 50 young talk clubs were formed and six pupils trained from each school on peer education, club leadership, and reproductive health issues. The presenter noted that gender inequality was one of the drivers of HIV infection. Culture does not allow people to talk about sexual issues but the same culture has some assumptions on which body changes influence (initiation) sexual activity. The study found a lot of activities peer educators were involved in i.e. creating opportunities for discussion of RH, use of drama and sports, informed children. The project also helped schools benefit by reducing the workload of teachers delivering RH messages, and at the individual levels there were more children able to appreciate body changes in themselves. Peer education works among young people.

**Discussion**

The moderator noted that when there are two programs- one at school and one at a community clinic, unless there is a link then it will not work. The moderator wondered how do we assess/evaluate interventions among young people? She said this because research in Malawi and Ethiopia had shown increased use of contraception over two years. Research in the USA shows that peer education programs tend to benefit the educators, and not the audience. The moderator felt that there was a need to design programs in Africa to generate best practices. In India, research shows that poor people ages 15-40 tend to use sterilization.

A Ugandan participant noted that the Indian study was looking at young married youth, but she preferred it looked at in-school and out-of school youth instead in line with MDGs. To what extent has use of contraception helped Universal Primary Education? She asked if all schools in Africa can be enriched with RH programs so that when people grow up they know their sexual rights so that even though children drop out of school, they know their rights. The presenter responded that STF been able to bring UPE on board in terms of sex education by having the first message as abstinence. They talk to teachers and leave it to the teachers to talk to children since it is illegal in Uganda to distribute condoms.

On the question of what response they had received from parents and their concerns with the RH programs, the presenter said they involved religious, political, and community leaders to understand what they are doing and clarify all questions they have to assure the leaders that all interventions are beneficial. They also show the parents the problems coming from non-interventions e.g., if child aborts in secret, it will still come out. Parents would then encourage children to attend RH meetings because they know the information is ok.

There was a concern for the out-of-school children. Most studies focused on school children because out-of-school children are harder to mobilize. There is a need to re-evaluate the programs so that everyone does not do in–school studies. Also the in-school programs mainly include reading materials, which means the reading culture needs to improve. There was a concern for youths with special needs accessing information since STF has mainly magazines. Participant said they have brail for blind adolescents in her country.
A local government official thanked STF and asked about the strategies for places where there is informal education where people join when they are older? The presenter noted that they target out-of-school youth by using video shows since out-of-school youth are idle and attend video shows. The presenter from STF mentioned how they are trying to deal with alternative basic education for the Karimojong. Teachers are trained on adult-child communication and dialogue. Also, STF produces papers in local languages. The messages given to adult children discuss all strategies and are more comprehensive for the adult children. He noted that STF works with out-of-school youths as well even though this presentation was for in-school youth. Local CBOs also conduct educational drama shows for the out-of-school youth in communities surrounding the schools in addition to the other RH work CBOs do. The presenter from India said that it is very unlikely for married women to be in school, so they are out of school, but data is stratified according to how many years of school one has had.

In response to the question about which methods of contraception peer educators were using and what was the criteria for distributing contraception, the Malawian presenter said only condoms and pills and when they find something outside their scope they were told to refer the patient. Youth were reporting that their parents were finding out about their RH issues and so health workers had to be re-trained on confidentiality.

Nigeria current NDHS shows some states have a CPR of 1%. There was a suggestion that they could pick a leaf and collaborate with Pathfinders, PATH, etc to create demand for contraception. Partners look into facilities while the program creates demand. For out-of-school programs, they used youth-serving organizations to take care of out-of-school youths in that area using radio and videos to form listeners clubs. At end of program they gather and discuss issues. For home videos, tapes and batteries were provided. They were encouraged to make use of the period after the first half of the premier league football match to show the video. This helps to stimulate discussion on what is seen in drama. This was in response to a community worker who said she found it difficult to mobilize youth in her area and wanted tips on how to do it.

One presenter from the multi-sectoral program GMDS made a general response saying that she only presented part of the program but there are other branches that include out-of-school youth. She said that there are two or three studies in Africa analyzing the impact. What they are trying to do in Mozambique is to combine all the studies and analyze all data if possible to see how the program has impacted the lives of young people. There are still many questions for them to answer.

One participant said he wanted presenters from Uganda and Mozambique to share lessons learned and challenges of scaling up, though there was not enough time to review this.

SESSION B03: CONTRACEPTIVE USE: LEVELS AND TRENDS II

Moderator(s): Betty Kyaddondo, EARHN, Uganda; Anne R. Cross, ICF Macro, USA

Presentations

Paper 1: Strong Predictors of Unmet for Living and Spacing Births in Sub-Saharan Africa
Presenter: Keriann M Schulkers, Management Sciences for Health, United States of America

Summary of Presentation
Many developing countries still face a large unmet need and its devastating consequences. It is to this background that the study using multivariate analysis was carried to establish the predictors of unmet need for family planning in 29 Sub-Saharan African countries. The presenter noted that predictors for unmet need vary significantly by type of unmet need. There were large differences observed between predictors of the unmet need for spacing births and the unmet need for limiting births. So in examining the total unmet need for FP was necessary in order to develop effective programs and policies. The presenter recommended the need to for further research to examine the unmet need for spacing and the unmet need for limiting rather than the unmet as a whole.
Paper 2: How Can You Address the Sexual and Reproductive Health Needs of Clients-Including Unmet Family Planning Needs- If You Cannot Say the Word “Sex”
Presenter: Caroline Mackenzie, Family Health International, Kenya

Summary of Presentation
The presenter said the study set out to establish knowledge, attitudes and practices of sexuality counseling among family planning and HIV service providers. They were also interested in knowing the barriers in communicating messages on sexuality to clients. The findings of the study presented lack of knowledge and training on sexuality counseling among the FP and HIV services providers. Most of the providers felt uncomfortable if a client asked about sexual practices especially those who considered it as a taboo. The presenter noted further, that some providers were not comfortable offering family planning services to young people. Among the identified barriers in communicating messages on sexuality were limited knowledge and insufficient skills. The presenter recommended that the knowledge, attitude and skills gap be addressed to prevent unwanted pregnancies and people getting HIV/STIs.

Paper 3: Wanted and Unwanted Fertility, Family Planning and Contraceptive Use Dynamics in India
Presenter: Hemkhothang Lhungdim, International Institute for Population Sciences, India

Summary of Presentation
With 42 percent of all births being unwanted (unplanned or mistimed) as of the 2005/06 NFH-3 in India, the country continues to have the second highest population in the world. According to the presenter, 21% that had occurred 5 years prior to the survey were unplanned, unwanted or mistimed. The regions in India found to have the highest unwanted/unplanned or mistimed births were central and Eastern with 30 and 24 percent respectively. Women less likely to use FP were young aged 15-24 (23%), uneducated (52%), Muslim (46%), Tribes (48%), poor (45%), with two children and had no son (53%). Older women who were non poor, educated, in nuclear families with 3 and above living children were more likely to have unwanted births compared to their counterparts. The presenter recommends the need for family planning programs to address the high unmet need for family planning in the regions. It is pertinent that unwanted fertility be addressed in order for the country to have fertility reductions.

Paper 4: Retrospective Case Notes Review Minilaparotomy and No-Scalpel Vasectomy Procedures Performed at Dessie FGAE Clinic, North East Ethiopia; A 10-year Period Review
Presenter: Netsanet Fetene Engender Health, Ethiopia

Summary of Presentation
The presenter said that a large proportion of women were in need of limiting their family size. Although the surgical contraception method of choice remains low in Ethiopia a large proportion of men and women have large family size. It is to this that they set out to review the socio-demographic characteristics and clinical course of clients who underwent voluntary surgical contraception through minilaporotomy (mini-lap) and No-scalpel vasectomy (NSV). Findings show the mean age for having a TL and vasectomy in Ethiopia was at 35 and 47 years respectively. Majority of the clients who received the surgical methods were from rural communities with no formal education. Information about sterilization was mainly field workers and health professionals. As expected, male involvement in sterilization was much lower than females. The presenter proposed the provision of surgical methods of contraception and mobile and static services to reach out to many people.

Discussion
The paper on Sub-Saharan Africa and the paper on Ethiopia raised heated discussions as people asked a number of questions to the presenters. To the Ethiopian presenter, a participant said according to his presentation, the average age of females accessing sterilization was 35, did they find out how many had had a child or not before sterilization? He was also asked about the long term effect of the rapid increase in contraceptive prevalence by the ministry. In response, the presenter pointed out that sterilization was not conducted to females below 30 years, he however said that majority of Ethiopian women married at an early age 16 years. So by age 30 they already have the desired number of children, he further promised to explore the issue of age and children ever born. As regards to contraceptive use, Ministry of
Health-Ethiopia had made a deliberate strategy to increase the contraceptive prevalence by training close to 30,000 health workers to reach out rural communities.

Paper 1 presenter was asked about the rational of using Neo-maternal model 3 and 4 and why he concluded that it was useful predicator on unmet need. The other concern raised was that most African countries do not collect information on neo-natal mortality so how did he go about that? The presenter’s reaction was that Demographic and Health Surveys collects information on neo-natal mortality so that information was available, the first question was unfortunately left un answered.

One participant was particularly disturbed about Paper 2 on Kenya, and he wanted to know who was responsible for talking about sexuality and SRH if the health workers were not. The presenter revealed that the project was developing training guidelines to be adopted by the Ministry of Health-Kenya, which would be used for all health workers. In addition she mentioned that the tools would be pre-tested first in the project area before being used elsewhere.

In India the question of unmet need versus unintended births is still high. Over time the National Health Surveys equivalent to DHS conducted show that most women want to have only 2 children. Total wanted fertility has been declining which is a reflection that if the unintended births could be prevented then the total fertility rate would reduce to 2.1 above replacement level.

**Key Recommendations**

There is need for an extended analysis to explore the reasons why people are not suing family planning methods not just unmet need. Tubal sterilization and Vesectomy under LA is an ideal method in developing countries to reach the underserved population where access to family planning and reproductive health services are not widely available. Health workers’ curriculum should include a component on sexual and reproductive health counseling and talks to their clients. They should be trained to talk to their clients in order to scale up contraceptive use. Examining specifically the unmet need for spacing and the unmet need for limiting rather than the unmet need as a whole.

**SESSION C03: GENDER AS A SOCIAL DETERMINANT IN FAMILY PLANNING**

*Moderator(s):* Mubarak Mabuya, Ministry of Gender, Labour and Social Development, Uganda; Lynn Bakamjian, Engenderhealth, USA

**Presentations**


**Presenter:** Carie Muntifering, Johns Hopkins School of Public Health

**Summary of Presentation**

By way of background for this presentation, the presenter discussed the low contraceptive prevalence for sub-Saharan Africa as compared to other regions in the world. Although the prevalence within Africa varies from 3% in Chad to 61% in Algeria, the region lags behind all other regions in the world. Women’s autonomy is another indicator that varies across the region. However, research has been inconsistent on the relationship between women’s empowerment and reproductive health. Coital frequency is another variable that is important but often overlooked in this analysis. In Asia, the presenter discussed the increase in coital frequency as relationships became more romantic. The research goals were to understand the relationships between the use of contraception and the timing of recent sex; and to understand the relationship between female empowerment and timing of recent sex.

For the analysis, the researchers used 6 countries in sub-Saharan Africa: Mali, Ghana, Uganda, Malawi, Zimbabwe, and Rwanda. They used the most recent data from the Demographic and Health Survey and excluded women who were single, divorced, widowed, in a polygynous relationship, or pregnant. The
adjusted hazards ratio showed that there was a strong association between contraceptive use and recent sexual activity. It also showed that women with higher levels of empowerment are less likely to report sex in the past month.

In terms of limitations, the study used only cross-sectional data and therefore causality cannot be analyzed or determined. Secondly, only six countries were used in the analysis. These countries were chosen so that they were diverse in location and history of colonization. However, they do not represent the entire continent. Finally, the researchers would have preferred to use sexual frequency as a variable but it was not available in the DHS. This study is one of the first studies that uses last sex as a variable and offers insight into relationships. It shows that couples that use contraception tend to have more sex- a finding that can be used to advocate for contraception in sub-Saharan Africa.

**Paper 2:** Do Contraceptives Fail? Investigating Claims of Contraceptive Failure Among Women of Reproductive Age in Nigeria.

**Presenter:** Oladipupo Banji Ipadeola, Society for Family Health, Nigeria

**Summary of Presentation**

The presenter began by discussing a decline in contraceptive prevalence rate in Nigeria from 2005 to 2007, which is sometimes attributed to claims that contraception fails and that it results in unintended pregnancy. The study investigated claims of contraceptive failure for women in Nigeria between the ages of 15 and 49. It used data from the National HIV/AIDS and Reproductive Health survey. Multiple logistic regression was used to explore factors associated with the outcome. The analysis included several other covariates including the age at the time of pregnancy and the type of contraception used.

The analysis included a sample of 5301 women. 22.1% of them had ever used contraception. Of these, 26.7% had become pregnant while on family planning. Contraceptive failure was highest among women under the age of 25 (85%). The analysis showed an increase in contraceptive failure among those with more education. Oral contraceptive pills accounted for 34% of all failures, followed by condoms.

In terms of implications of this analysis, the presenter asserted that special interventions should be designed to target young women in urban areas of Nigeria and that education on the proper use of oral contraceptive pills was needed. Finally, the author suggested that long term methods with lower user misuse and therefore lower failure rates should be promoted.

**Paper 3:** Gender Equitable Teachers Support Contraception and Small Family Norms: Findings from a School Based Intervention in India.

**Presenter:** Pranita Achyut, International Center for Research on Women, India

**Summary of Presentation**

This work was based on the premise that gender inequity adversely affects sexual and reproductive health. The presenter asserted that few studies work to change these norms and this study attempted to do just that. The Yaari Dosti and Sakhi Saheli interventions have been successful at changing attitudes and served as the basis for this study's intervention. The aim of the intervention was to reinforce alternative conceptions of masculinity and create an enabling environment to work with the youth. The study was designed to target teachers to educate them to create a more equitable relationship between boys and girls in the classroom.

The intervention was a two-day training for teachers and trainers and included a pre and post assessment of attitudes towards gender equity. After the training, teachers were more accepting of gender equity had more equitable attitudes towards family planning. The in-depth interviews showed a disturbance in the teachers' thought processes. Even after the training was completed, they continued to question gender relations. Initially, the participants had been apprehensive and hesitant to discuss gender norms. There was denial of gender-based discrimination and then justification of it. During the intervention, the trainers caused the participants to question the assumption that the classroom is gender neutral. The training resulted in increased support for family planning behavior.
**Paper 4:** Gender Equity, Gendered Roles and Reproductive Health in Maasai Women in Northern Tanzania  
**Presenter:** Yadira Roggeveen, Endulen Hospital, Tanzania  
**Summary of Presentation**

Dr. Roggeveen’s presentation was based on her work at Endulen hospital in Northern Tanzania, which was initially founded as a TB center. In this area, there is very low hospital delivery. Due to late presentation, many of the women who go to the hospital have severe complications and there is a high level of maternal mortality. Therefore, there is a great deal of distrust for hospital deliveries. The goal of the analysis was to learn how gender roles and hierarchies affect sexual and reproductive health. Since the Maasai constitute 80% of the hospital patients, the analysis focuses largely on this ethnic group. The researchers talked to traditional birth attendants (TBA’s) as well as Maasai men and women. They found that the polygamous marriage structure is vital to Maasai survival and their way of life. Sexuality is seen as a very important part of social interaction. In fact, a group of men can agree to share wives. This is done for both sexual satisfaction as well as a way to provide protection for the women. Sexuality can also be transactional and provides some women with a means of providing for their families.

In terms of family planning for Maasai families, the Maasai feel the need for more children. If their spouse is sterile, Maasai men and women will use another partner to achieve their fertility goals. However, they also desire fewer children when resources are meager. Women with a complicated last pregnancy are often reluctant to have more children. Finally, women who engage in transactional sex for financial support often do not want to become pregnant. This shows the heavily pronatalist culture of the Maasai but also illustrates that there are opportunities for family planning. Dr. Roggeveen also showed accessibility and availability as major barriers to family planning for those with unmet need. In terms of a way forward, Dr. Roggeveen showed the need for careful education about family planning. Otherwise, increased use of family planning could result in an increased risk of HIV/AIDS and other Sexually Transmitted Infections (STI’s). She also advocated for men’s sexual and reproductive health services.

**Paper 5:** Qualitative Research on Gender Norms and Family Planning Decision-Making in Tanzania  
**Presenter:** Sidney Schuler, AED, United States of America  

In Tanzania, gender norms support high fertility. Therefore, a change in gender norms could result in an enhancement of reproductive health. This study occurred in three areas in Tanzania and included 30 recently married men and women. It solicited their definitions of masculinity and femininity. According to this group, men are the household heads and the providers for the family. They are supposed to have a lot of sex and satisfy women and to have many children. Women’s duties, on the other hand, are to support their husbands and take care of the household.

Thus, there are norms regarding sex, childbearing, family size, decision-making, contraceptive use and violence against women. In these communities, men and women are only judged as complete if they have children. The man is the person who is supposed to decide on family planning in the household and it is accepted when he has extramarital relationships. In terms of family planning, there was a high unmet need in the study sample. A desire to space or limit was expressed by 21 of 23 non-users. Men and women also cited benefit to spacing and limiting including more attractive women, healthier women and healthier children.

However, contraceptives are also perceived to cause cancer and weight gain and this fear drove men and women away from using contraception. In this setting, gender norms and misconceptions are major barriers to contraceptive use. Male dominance and reluctance to use family planning is a major deterrent to its use.

In terms of recommendations, the presenter suggested that we work to address inequality and fears and misconceptions. She also discussed the need to strengthen the capacity of clinics. Finally, we need to provide information from reliable sources and eliminate the need for members of the community to rely on each other.
Discussion

The first presentation was discussed first while the panel waited for 2 more panelists to arrive. Audience members thought that the reported sexual activity sounded low and asked about misreporting and variation between countries and tribes. While misreporting could very well be an issue, Ms. Muntifering presented the debate on whether the reporting would be higher or lower than the truth. Another audience member asked why the six countries were chosen and why only six were included. Six countries were chosen due to time constraints and were picked because they were from different regions, had different histories of colonization and had variable contraceptive prevalence rates. However, Ms. Muntifering acknowledged that it would be useful to repeat the analysis with more countries to increase generalizability.

The second discussion targeted the rest of the presentations. The second paper was confronted with questions about which methods were being discussed and the reasons for the contraceptive failure. He explained that all methods were being researched and that adherence problems resulted in the failure of oral contraceptive pills.

One audience member asked if there are sexual educational programs for girls in India that could heighten their empowerment. The presenter responded that while there was sex education for youth 15 and older, it has been revoked for fears that they were too young. For 17 and 18 year olds, there continues to be sexual education programs.

The Tanzanian presentations were addressed jointly for questions. They were asked whether they give counseling for hormonal methods is given before they are dispensed. While counseling is offered to women who go to clinics, many women do not present at the clinic for family planning. Also, although contraceptive counseling exists, counselors are often overwhelmed and perhaps the quality of care is not as good as it could be. Another audience member asked if they see a lot of unwanted pregnancies in Tanzania due to low contraceptive prevalence rates. Indeed, at Endulen hospital they see a lot of incomplete abortions and family sizes are larger than are often intended. Therefore the challenge is to create communication programs to disseminate gender messages and promote spousal communication.

Key Recommendations

Advocacy messages for contraceptive use in the community should include information that couples using contraception have more sex than those that do not. Studies on coital frequency, contraception use and female autonomy should be expanded to gain an understanding of household dynamics and contraceptive use. Educational programs to train women on the correct use of oral contraceptive pills should be undertaken to reduce misuse and contraceptive failure. Counseling about HIV and STI’s should accompany family planning counseling in order to prevent outbreaks of these infections. Provide reliable information to potential users instead of relying on them talking to each other and sharing information.

SESSION D03: INTEGRATING FAMILY PLANNING AND MATERNAL AND CHILD HEALTH I

Moderator(s): Hanifah Sengendo Naamala, Save the Children, Uganda; Mario Festin, WHO, Switzerland

Presentations

Presentation 1: Postpartum Family Planning in 17 Countries
Presenter: Maria Raquel Borda, Futures Group

Summary of Presentation
Concerned about the high unmet need for FP among postpartum women in Uganda (where 4 out of 5 women want to delay or limit their next birth but are not using a form of contraception), the researchers set out to contribute to reducing this unmet need by carrying out this research to show that higher FP use
at the country-level will be associated with longer birth intervals. This the researchers believed will
translate into good health for the entire family. They also hypothesized that exclusive breastfeeding will
be associated with slower return to sexual activity and return of menses. They did a secondary analysis of
Demographic and Health Survey (DHS) surveys from 17 countries spanning Central Africa, East Africa,
West Africa, South Asia, and the Caribbean. Against their expectations, the analysis showed that high
levels of exclusive breastfeeding in a country do not automatically associate with longer birth intervals for
that country. The presenter gave a couple of interpretations to this. First, in countries where exclusive
breastfeeding is not commonly practiced for a full six months, other methods of family planning are used.
Another possibility is that the indicator of exclusive breastfeeding measured by the DHS is not restrictive
enough the presenter added. With respect to FP use, the presenter indicated that there was a higher FP
use among women who have had adequate ANC and among women who delivered at a facility. Women
whose menses had not returned tend not to use FP methods. The presenter concluded that the
programmatic application of their findings will be to encourage use of maternal health services, and build
awareness that, return of fecundity often precedes menses and encourage early FP use.

Presentation 2: A Literature Review of the Integration of Family Planning Services with Other Health
Services
Presenter: Lorrie Favin, Centers for Disease Control and Prevention (CDC)
Summary of Presentation
Many calls exist for integration of FP and other services as a way to address unmet need for family
planning. That which is not established is an evidence base for the effectiveness of such an approach,
the presenter noted. She also added that previous reviews have focused on the integration of family
planning with a specific type of health service. The researchers reviewed the literature for the current
state of knowledge about the effectiveness of integrating family planning services with any other health
services. They searched five databases and initially got close to 600 abstracts. Of these, only 80 were
relevant, 15 of these articles were reviewed and 9 included in the study results. This review indicates
that existing research provides some evidence suggesting benefits of integration and helps to generate
hypotheses. The presenter, however, noted that well-designed, further evaluation research of family
planning programs integrated with other health services is still needed.

Presentation 3: The Fight for Maternal and Child Health is Won in the Community
Presenter: Feven Tassew, CARE Ethiopia
Summary of Presentation
CARE Ethiopia has been implementing Family Planning (FP) Programs and Maternal and Child Health
Projects since the 1996. Their projects use community mobilization approaches which lead to behavior
change with significant success. Their Health Program Coordination Unit conducted a program review to
examine strategies from current and previous CARE Ethiopia projects dealing with child and maternal
health, family planning and HIV. The presenter talked about the two most successful of their projects.
First, aUSAID funded child survival project, which according to the presenter averted close to 1500 child
deaths, and improved child and maternal health care practices significantly. The data show that women
who initiated breastfeeding within an hour of birth increased from a baseline of 33% to 77%; and children
given complementary food (6-9 months) increased from 36% to 98%. The second project the presenter
talked about was the one funded by the Royal Netherlands Embassy which improved access to Family
Planning and HIV/AIDS services and increased Contraceptive Prevalence Rates (CPR) in the target
areas. The increase in CPR according to the presenter was attributed to their training of numerous
community health workers and the establishment of a community distribution system.

Presentation 4: Integrating Family Planning into Postpartum Care: A Postpartum Family Planning Needs
Assessment in Cap Haitien, Haiti
Presenter: Youseline Telemaque, Konbit Sante Cap Haitien Health Partnership
Summary of Presentation
Haiti has one of the highest maternal mortality ratios in the world. This statistic according to the presenter
is closely related to poor access to family planning services. As such in Haiti currently, family planning
strategies are proposed as a method of primary prevention of maternal mortality. This study evaluated the
knowledge, acceptance, and desire for contraception in postpartum women. The study additionally
determined the level of knowledge, attitudes, and practices of the health care providers on the maternity service in the area of family planning. The researchers employed both qualitative and quantitative methods in the implementation of the research. Data from the qualitative component of the study revealed that majority of patients reported receiving all of their FP information from family and friends. Most women expressed a desire to space or limit their pregnancies. Some of the militating factors against the realization of these desires the presenter stressed included economic hardship, and fear of side effects. Providers at all levels report of a lack of systematic FP counseling and method provision for postpartum women. The presenter also used data from the quantitative aspect of the research to show that, mistimed pregnancies were associated with age, while women using FP were less likely to report mistimed pregnancies.

Presentation 5: A Model of Integration: Postpartum Family Planning through a Community Based Maternal and Newborn Program

Presenter: Salahuddin Ahmed, Johns Hopkins Bloomberg School of Public Health

Summary of Presentation
Using evidence from the 2007 Bangladeshi DHS, the presenter showed that unmet need is high in Bangladesh, but higher in the area that this study was conducted – Sylhet. The objective of the study was therefore to develop and test an integrated Family Planning, Maternal and Neonatal Health (FP/MNH) service delivery approach, to assess the strengths and limitations of integration, and the impact of the intervention package on FP. The researchers employed a quasi-experimental design, with evaluation primarily done through pre-post household surveys in non-randomized manner. The project was able to employ interventions that strengthened capacity of the health workers working in the intervention area through training and orientation, and at the household level through one-to-one counseling, at the community level through social mobilization and community participatory meeting and at facility level through family planning counseling by service provider. These were achieved by employing the project’s innovative Community-based Advocacy and Behavior Change Communication strategy the presenter stressed. As part of the intervention, the project also trained young women with grade 10 education from the local community on MNH, as well as FP. Some of the challenges the researchers faced according to the presenter were limited mobility of women, limited availability of FP methods, and misconceptions on return to fertility by both clients and providers. The researchers learned that FP messages are well integrated into the MNH counseling curriculum, and that integration was feasible for community health worker’s workload, as it did not adversely affecting the quality of the MNH counseling.

Discussion
Can family planning really be the solution for the people of Haiti? The fourth presenter in addressing this stressed that FP though very important is not a magic bullet. She acknowledged that the unacceptably high maternal mortality rate in Haiti can be significantly reduced if FP (particularly prevention unsafe abortion through FP) is welcome. FP is part of the solution, not the only solution to the problem she added. Responding to a request from the audience to share the Bangladeshi experience on courting community members to buy into their community-based initiative, the presenter explained that the project spent quite some time explaining to them the relevance of the program particularly FP. A clarification request directed to the presentation on “Postpartum Family Planning in 17 countries” was also addressed. The presenter was commended on her succinct delivery, but was asked to clarify the terms “prospective unmet need” and retrospective unmet need” for the benefit of the larger audience. In addressing this, the presenter indicated that they defined unmet need in one of two ways; first unmet need status was based on the fertility preferences of clients retrospectively at the time of their most recent pregnancy. The second possibility according to the presenter was to define unmet need status based upon their fertility preferences at the time of the survey interview or prospectively. She added that Ross and Winfrey (2001) had shown that alternative definitions of unmet need in the postpartum period can have serious impact on the estimated number of women with unmet need. Also discussed was how sustainable it was for the project being implemented by CARE International in Ethiopia to be training community health workers. The presenter acknowledged the challenge but explained that the government of Ethiopia has a similar program where community health workers are paid by the government. The presenter was hopeful that their project findings will be welcome by the government and their plan to scale it up will be taken up by
the government. In rounding up the session, the moderator remarked that advocates of FP whenever they have the opportunity to talk to a mother about pregnancy or FP should also remember to talk to her about the unborn baby. In so doing, the spirit of integrating FP and MCH services will be rekindled. The moderator also added that even though the findings and recommendations presented by the various researchers may be peculiar to their circumstances it could be adaptable to other populations.

Key Recommendations

Emphasize improved provider education related to comprehensive family planning. Expand family planning eligibility to include all women irrespective of physiologic state or age. Integrate comprehensively family planning services into postpartum care. Collaborate with the Ministries of Health to emphasize improved provider education. Expand contraceptive choices/options to cover immediate postpartum so as to decrease unmet need for family planning among women receiving care

SESSION E03: FAMILY PLANNING AS A COMPONENT OF SRH

Session Chair: Laura Laski

Note: This session aims to showcase UNFPA’s various strengths and what UNFPA will bring to the field in the new aid environment.

Presentations

Presentation 1: Financing FP/ SRH Programs, and Prioritizing Them within National Plans and Budgets
Presenter: Dia Timmermans, UNFPA

Summary of Presentation

UNFPA is currently working with country national plans to make sure reproductive health is included. UNFPA will engage comprehensively in technical budgetary discussions and be part of the Health Sector Strategic Plans at the national, district, and subdistrict levels. This is a new way of working for UNFPA—for example, it no longer works on separate reproductive health plans.

Through this strategy, UNFPA has worked with one national development plan in countries (sometimes PRSPs) and found that very few plans had any mention of family planning. UNFPA has found that strong national ownership is key for declarations and that use of national systems for contraceptive procurement, audits, and reporting are most efficient and effective. UNFPA has been advocating for increased budget support in these national plans so that there is a reduction in the level of project-funding and an increase in bilateral funding of governments. UNFPA is becoming more results-based and not just activities-based. Finally, UNFPA is implementing mutual accountability, where civil society and partners are as responsible for results as well as the government. A recent success story for this strategy is Tanzania. Since 2003, UNFPA has been active to ensure commodities have become part of pooled and government funding. As a result, in 2006, most of the funding for commodities came from the government of Tanzania.

Presentation 2: Prioritizing FP/ SRH and Working in the New Aid Environment
Presenter: Wilfred Ochan, UNFPA Uganda

Summary of Presentation

In Uganda, UNFPA has worked very closely with the national governing authority, and in particular the national development plan authority to help develop a new national development program that includes sexual and reproductive health. UNFPA is also making sure sexual and reproductive health is included in other national level plans. In addition, UNFPA is involved at the secretariat level to make sure plans cover sexual and reproductive health in related non-health sectors. Furthermore, UNFPA participates in various working groups to ensure that family planning/SRH topics relevant to the tech working group are represented. UNFPA participates in policy level discussions. By working through the government system, UNFPA eliminates the possibility of setting up unnecessary parallel systems. Finally, UNFPA ensures that
district plans and district budgets integrate sexual and reproductive health and family planning as well. In the future, UNFPA Uganda plans to start tying to government level planning cycles.

The discussion after the presentation focused on allocation of the national budget for reproductive health and family planning. The parliament has refused to approve the current budget because it wants to know exactly how much is allocated for reproductive health in order to ensure accountability. Approximately 1.5 billion shillings (or about $900,000) is currently budgeted for family planning; this represents less than 10% of total requirement for family planning commodities. Therefore, UNFPA is doing advocacy activities with parliament in order to ensure more funding is given for family planning and reproductive health. UNFPA is also working at the district level on plans for other health interventions and making sure that indicators and budgets at this level has integrated family planning.

The presenter explained that Uganda was undergoing a decentralization of its health system, which brings in more stakeholders in the planning process. While this has made the process more democratic, it has had a negative impact on reproductive health. UNFPA hopes that by transferring strong central-level champions who had been working in vertical programs to the district level will ensure that reproductive health/family planning are not be overlooked.

With regard to partnerships, UN agencies in Uganda have a joint program on HIV/AIDS as well as a joint program on gender. There is also an evolving joint program on population and development. UN agencies signed a joint commitment last September, and they are currently working on a report and framework.

Furthermore, UNFPA is trying to leverage HIV/AIDS funds for family planning. It participated in the Global Fund Round 9 proposal process, in particular the integrated service delivery portion.

UNFPA recognizes that it needs to conduct more advocacy activities at the district level. It is especially difficult to raise awareness of prevention because most people care about diseases that are obviously visible. More advocates are needed to talk about reproductive health and sexual reproductive health. Perhaps a good investment would be to build capacity at the district level for reproductive health.

**Presentation 3: Family Planning as Part of Comprehensive SRH**

**Presenter:** Berhanu Legesse; Helene Amdemikael, UNFPA

**Summary of Presentation**

The Berhane Hewan project, implemented in rural Ethiopia (specific districts in the Amhara region), offers a package of interventions carried out by Ministry of Youth and Sports. The program deals with a wide variety of SRH issues, but the presentation focused on the subject of delaying early marriage (therefore delaying childbearing) and improving reproductive health for health and development. Though government partners implement the program, UNFPA helps with planning at the district level and then works with the mentors at the community level.

Berhane Hewan has created a space for people to discuss family planning. Mentors undergo several weeks of training on the methodology and then hold two sessions a month with adolescent girls. UNFPA also conducts multiple house to house visits, registering them and following them and getting consensus?

**Discussion**

One audience member advertised workshops that DSW will conduct for members of civil society organizations. Contracted by the WHO, DSW have been implementing multi-country capacity building workshops on the evolving aid environment and on development of advocacy action plans specific to identifying strategic opportunities and increasing funding for family planning and reproductive health. There are two more workshops scheduled, in Bangkok and Burkina Faso.

Another audience member mentioned several tools that are available specifically for advocating for integrated HIV/AIDS/Family Planning programs. They are: 1) A Practical Guide to Integrating Reproductive Health and HIV/AIDS into Grant Proposals to the Global Fund and 2) Guidelines for
Integrating Sexual and Reproductive Health into the HIV/AIDS Component of Country Coordinated Proposals to be submitted to the Global Fund.

In conclusion, UNFPA works very differently than other implementing partners. It works closely with the WHO, other UN programs, and other development partners to harmonize their efforts. UNFPA plans to expand their focus to technical support and capacity development, not only of governments but also of civil societies. In this way, it will be less affected by a changing aid environment as it will always have the ICPD/MDG agenda to promote.

SESSION F03: EFFECTIVE PROGRAMMING AND SERVICE DELIVERY II
Moderator(s): Florence Maureen Mirembe, Makerere University, Uganda; Frank Taulo, Center for Reproductive Health, Malawi

Presentations

Presentation 1: An Innovative Approach to Increasing Uptake of Long-term Family Planning Methods in Zambia
Presenter: Josselyn Neukom, PSI
Presentation Summary
Zambia is a large country with increasing fertility, especially in rural areas. Most women seeking MCH services use the public sector, which encompasses 1500 government clinics throughout the country, in contrast to only 115 private clinics. Levels of IUD and injectable use are very low throughout Zambia. Through conversations with reproductive health service providers, the presenter found that the HIV/AIDS epidemic drastically impacted MCH services, and MCH providers were asked to take on additional responsibilities. The goal of the project was to provide highly skilled family planning professionals at public hospitals to supplement the current staff. The aim was not to replace the family planning environment, but to expand it. The program trained medical professionals in IUD insertion and provided supplies, equipment, and informational aides to the service providers. The providers also provided information on family planning to women while they were waiting for MCH services, and provided other contraceptive methods as well. A key aspect of the program is that the client would see the same provider for IUD insertion and for follow-up visits, which fosters personal connections and increases acceptability. The program served over 25,000 women in the first year, and tripled to quadrupled the usage of IUDs in Zambia. The program has had a relatively low cost in comparison to other country programs. The presenter noted that only 10% of the clients were from rural areas, which is an aspect that the program hopes to improve in the future.

Presentation 2: Contraceptive Initiation Simplified: Health Providers Experience Using Family Planning Checklists
Presenter: Beatrice Atieno Ochieng, FHI Kenya
Presentation Summary
The project arose from the issue that service providers in Kenya and Guatemala are unable to confirm that a woman is truly pregnant when she is not menstruating. The presenter created a checklist for determining pregnancy and also developed a checklist for medical eligibility of contraception use. The project team put the ministry emblem on the checklists to increase their acceptability, and distributed them to service providers. The effectiveness of the checklists were measured through surveys and in-depth interviews with the providers. 73% of service providers found the checklists to be very useful, and the benefits include time reduction and a reduction in provider bias. The presenter stated that as new information emerges, the checklist may be altered to maintain relevance and effectiveness.

Presentation 3: Current Practices of IUD Insertion among Physicians in Central America
Presenter: Isolda Fortin, PSI Guatemala
Presentation Summary
The project aimed to research the potential barriers to IUD use in El Salvador, Nicaragua, and Guatemala. The project team conducted in-depth interviews with service providers from the three countries and compared information from public sector, private sector, and NGO service providers.
Information from these interviews revealed that physicians recognize many of the benefits of IUDs, but myths and personal religious beliefs act as barriers for effective IUD service provision. The project developed an intervention model based on the barriers to IUD service delivery and solutions to these barriers, which covers issues such as cost and the amount of time of the physician visit for an IUD.

**Presentation 4:** How Well Do National Family Planning Guidelines from Africa Adhere to International Guidance?  
**Presenter:** Lucy Wilson, FHI  
**Presentation Summary**  
The presentation discussed a national guidelines study, which collected reproductive health service delivery guidelines from 13 Sub-Saharan African countries and compared them to 21 criteria of the World Health Organization standards. The research team examined guidelines throughout the world through databases and personal contact. Country guidelines included medical eligibility guidelines for contraception and structuring of service guidelines. Malawi’s country guidelines scored the highest, while Ethiopia’s scored the lowest. Results showed that in general, guidelines that refer to service provided to HIV-positive women are sub-optimal. The presenter raised the issue of accessibility to WHO guidelines and suggested that WHO has a standard guideline available on the internet which is updated periodically as it is changed. This standard guideline should also allow for variations among countries.

**Presentation 5:** Removing Barriers to DMPA Continuation: Field-testing a Provider Job Aid in Senegal  
**Presenter:** Kate Rademacher, FHI  
**Presentation Summary**  
While injectables are highly popular in Sub-Saharan Africa, there are high rates of discontinuation. Discontinuation includes a woman stopping a method because of the side effects and also due to provider bias. In Senegal, it is common for women to be late to visit their providers for subsequent injections, and are thus denied a re-injection, even if they return within the “grace period” set by the WHO, which is two weeks before the re-injection date and four weeks after. The project tested re-injection job aides for providers, who offered suggestions for revision of the job aides for increased ease and effectiveness. The job aid is designed to be used for a variety of situations that could result in a woman being late for her re-injection date.

**Discussion**

Audience members asked the presenter of the first presentation about possible reasons for IUD removal, if the family planning providers earn a greater wage than government-paid service providers, and sustainability. In terms of tracking IUD removals, the presenter explained that initially, there were no providers trained in IUD insertion or removal, so the time shift in the buildup of IUD insertions may have created a deceptively high number of removals. On average, the family planning providers make 15% more money than government-paid service providers. However, when a government-paid service provider was asked if she was jealous of the extra pay given to the family planning provider, she responded “Who has time to be jealous?” indicating a general lack of bitterness about the topic. In terms of sustainability, the presenter explained that the primary goal of the project was to increase IUD use, and after a threshold is reached, women will begin to demand the IUDs. This is the only way to break a cycle of inconsistent service use and method delivery.

The audience asked the fourth presenter about the issue of changing guidelines, but not changing practices. The presenter responded that the guidelines are not “should” recommendations, they are “must” recommendations, and that every time a program begins, the country must update their guidelines.

The audience questioned the fourth presenter about the process a provider should take if the client is consistently late. The presenter responded that the job aides encourage providers to choose another contraceptive method if the client is consistently late, but being late a limited number of times can be fine. Additionally, an audience member commented that a way to overcome the issue of client lateness could be overcome entirely if the women had access to Uniject, in which they could provide the injections to themselves. The presenter agreed with this statement.
Key Recommendations

Long-term methods should be promoted as effective, cost-efficient methods of family planning. Working alongside an established family planning environment in order to enhance it, rather than replace it, can have dramatic impacts in contraceptive uptake.

SESSION A04: REACHING YOUTHS PROGRAMS FOR ADOLESCENTS II

Moderator(s): Adesegun Fatusi, Obafemi Awolowo University, Nigeria, Patricia Wamala Nansamba, Family Health International, Uganda

Presentations

Paper 1: Religiosity, Sexual debut and contraceptive use among in-school adolescents in Lagos State, Nigeria
Presenter: Olayinka Yetunde Asubiaro, Obafemi Awolowo University, Ile-Ife, Nigeria

Summary of Presentation

Sexual activity among adolescents is a serious concern in Nigeria as SRH burden is high among this population. Little is known about the effect of religiosity and sexual activity, and there is need to better understand the risk and protective factors of sexual behavior among adolescents to strengthen policy and programs. The study objectives are to determine sexual debut patterns among in-school adolescents assess the pattern of contraceptive use among sexually experienced in-school adolescents and determine the influence of religiosity on sexual debut and contraceptive use among respondents. Outcome variables include age of sexual debut and contraceptive use. Independent variables were internal religiosity and external religiosity. Christians and Muslims were compared. Data was collected through self-administered questionnaires. Results showed that:

- Males are more sexually active than females by a difference of 27% for males versus 20% for females that were sexually experienced;
- Late adolescents used modern FP compared to the young ones. Results showed that:
- Higher proportion of males used modern FP methods at sexual debut and during time of study;
- Males and females who had high religiosity had not initiated sex;
- \textit{Internal} religiosity and sex was significant among females while \textit{external} religiosity and sex was significant among males;
- Internal and external religiosity and FP not significant;
- However, external and internal religiosity was not a prediction to the use of FP;
- Early pubertal development and knowledge of HIV/AIDS, sexually active peers and parental communication leads to significant prediction of FP use;
- In summary, religiosity is a protective factor for sexual debut but the dimension varies by gender;
- Religiosity, however is not significantly associated with contraceptive use among sexually experience adolescents;
- Programming for AHD in Nigeria should take relevant cognizance of the effect of religiosity.

Paper 2: Knowledge and use of methods to avoid pregnancy at first sex: patterns and influence of family and school factors among a school-going sample in Mukono, Uganda
Presenter: Esther Babirye Kaggwa, Johns Hopkins University, United States of America

Summary of Presentation

56% of the population in Uganda is below 18 years. Country has one of the highest population growth rates. Low percentages of women report using a modern contraceptive method and there is significant unmet need among adults and youth. Study was a cross-sectional school-based study that randomly selected 10 schools in Mukono town council and data was collected between November 2007 and march 2008. A self-administered survey was used for school-age children and head teachers were interviewed.
Outcome measures include the number of pregnancy prevention methods known and use of a method at first sex. Independent variables include family factors (parent-child communication on sex and HIV/AIDS and parent monitoring) and school factors (number of school sources of health information and school performance). Results showed that:

- Most of the adolescents used condoms as a method 75.5% and 73% used condoms at first sex;
- Fear of side effects and fear of what other people would say were the most frequently cited reasons for not using a method;

Conclusions were:

- Parental/guardian communication doesn’t improve knowledge of methods known although it influence use of method at first sex;
- Number of sources of health information is not associated with methods known or used but unmeasured aspects of school seem to influence knowledge;
- Unmeasured school factors are not associated with first time use.

**Paper 3: Evaluation of community-based youth reproductive health communication intervention in Bihar for evidence-based advocacy and scale up**

*Presenter: Elkan Elijah Daniel, Pathfinder International, India*

**Summary of Presentation**

Standard behavior change approaches and strategies include: environment building, behavior change communication, improving access to services and capacity building of NGOs. The goal of the PRACHAR Project is to improve the health and well being of women, their children and families by reducing fertility through changing social norms related to early child bearing and inadequate spacing, and the objectives were to delay first child till woman is 21 years old and space the second child by 36 months. The evaluation plan included surveys at beginning of 2006 and end of 2008 of Phase II and an adolescent five year follow up study. The dependent variables (behavioral outcomes) were: current use of contraceptives, ever use of contraceptives, age of women at first birth and interval between 1st and 2nd birth. A longitudinal data analysis was used to measure the transition between unmarried and married and to having children and timing of contraceptive use. Key finding at the 5 year follow-up were:

Regarding contraceptive use:

- Contraceptive use before first birth was 3/75 times higher in the intervention group than in the comparison group;
- Contraceptive use after the first birth was also 6.08 times higher in the intervention that in the comparison group;
- Among those that used contraception before the first birth, subsequent use of contraception was 9.01 times higher than those who did not use contraception before the first birth;

Regarding implications for reducing population momentum:

- About 80% of population growth between 1990 and 2030 would be due to population momentum in India;
- A 2.5 year increase in age at first birth would reduce population growth momentum by 21%;
- Delaying and spacing children will provide substantial health benefits to mothers and children.

Evidence from PRACHAR showed that:

- Environment building activities with parents and community elders are essential for obtaining programmatic access to adolescents and young couples;
- Behavior change was greatest among couples reached as adolescents before the entered into marriage;
- Young men lead the change in reproductive behavior; change is more likely to occur when men are reached by the program, and greatest change occurred when both men and women were reached;
- Continued home visits to women to reinforce messages are imperative; behavior change was greatest among couples reached early after marriage and childbirth;
• Behavior change was greatest among couples reached with more than one intervention strategy, reached more than one life cycle stage and when women participated in decision making on contraceptive use.
• Male health workers are needed to reach men;
• Condoms are the most common contraceptive method (59%) used to delay first birth and space the second;
• Joint coordinated program implementation by the government and NGOs will facilitate acceptance of Prachar approaches and ensure government ownership of the scale up process to help promote sustainability and scalability to other districts and countries.

**Paper 4:** Adolescents living with HIV require sexual and reproductive health information and services
**Presenter:** Harriet Birungi, Population Council, Kenya

**Summary of Presentation**
Why are we not addressing contraceptive use and HIV positive patients? Answer: vulnerability of young people to acquiring HIV overwhelms concerns for those already infected and growing older; false assumption that there are too few HIV+ adolescents to justify special programming; HIV/AIDS care services are organized for infants and adults; and research on HIV positive adolescents has not necessarily addressed as important issues. In a study carried out at TASO, it was found out that the population of HIV young people is rapidly growing, and the population is living under vulnerability is growing i.e. 67% lost parents 30% out of school. The research questions: what desires and fears do HIV+ young people have around growing up, love, dating, pregnancy, having/ not having children and intimacy? The sample included 732 adolescents (15-19 years) perinatally infected with HIV and were recruited from 17 HIV/AIDS treatment centers. Contraceptive services are important for HIV+ adolescents because many are dating and desire to love and be loved: 41% have had a boyfriend/girlfriend; 39% are in a casual relationship and 83% of those not in a relationship would like to have a relationship in the future. Contraceptive services are important for this population because: 41% see no reason why young people living with HIV should not have sex; 44% want to have sex and think about it; 28% feel pressure from others to have sex; and 33% have had intercourse. Still 61% of the sexually active did not use any method for first sex (condom was most common method at 57%). 33% had ever had sex, 44% had the desire to have sex, and 61% of the sexually active did not use any contraceptive method at 1st sex. 39% used condoms, although 57% did not use consistently, 76% worried about pregnancy, 41% had the willingness later.

Program implications include:
• reorganization of existing HIV/AIDS services;
• introduce contraceptive services at HIV/AIDS treatment centers to expand method mix beyond condoms;
• introduce a ‘fertility and sexuality desire’ assessment tool for counselors to systematically screen and refer young people;
• And early identification of pregnant HIV+ adolescents.

Considerations for implementing interventions include:
• Improve life skills for HIV+ adolescents to understand their sexuality as they grow;
• Give HIV+ adolescents information and practical support to deal with being HIV+, make informed choices and balance responsibility with sexual and reproductive desires, and negotiate vital aspects of their lives, avoid infection of others and re-infection;
• Involve HIV+ adolescents in intervention development.

**Paper 5:** Evaluating programs reaching very young adolescents: Experiences and lessons from ‘My Changing Body,’ a body literacy and fertility awareness course for girls and boys entering puberty
**Presenter:** Susan Igras, Institute for Reproductive Health, Georgetown University, United States of America

**Summary of Presentation**
ASRH recognized as critically important issue worldwide but little progress yet on programs for very young adolescents. Age 10-14 is critical for development. There is changing body patterns i.e. physical,
emotional and social hence there is increased fertility awareness body literacy and self care. My Changing Body (MCB) addresses gaps in life skills and materials for use on VYA programs. The study centered on fertility awareness, body literacy and self care. Formative research was done to contextualize MCB in Guatemala, Madagascar and Rwanda. Tools included community and body mapping, story telling, video clips and collages. Findings from formative research include: poor fertility awareness and body literacy and gender and sexual norms influence responses to changes during puberty. Sample evaluation tools included card games, my universe and living with my changing body.

Conclusions:
- Similar levels of poor fertility awareness among youth and parents at baseline;
- Core gender stereotypes based on physical traits, parents less likely to classify based on traditional gender roles;
- VYA identify parents as key resource for puberty information.

After participating in MCB:
- Fertility awareness increases among youth and parents;
- More accepting attitudes towards youth sexuality;
- Parents consider themselves more accepting and knowledgeable (but no significant changes seen in youth);
- Trend towards greater parent-child communication, but only significant among parents;
- Parents and youth report greater confidence and ability to communicate;
- Shift towards more equitable gender attitudes among both;
- Parents more comfortable with changes in children during puberty, but no significant changes among youth.

Next steps:
- Further analysis (statistical tests, composite indicators, scales);
- Analysis of qualitative data;
- Testing in Rwanda.

Final thought on programs reaching VYAs:
- Content: six sessions can provoke significant changes in some areas and not others—VYA-serving programs may need to revisit certain themes and engage VYAs and parents again in discussions.
- Gender: gender awareness critical for health and well being-challenge is how to make discussions relevant and practical.

Key Recommendations
- Religiosity is a protective factor in sexual activity so should be advocated for.
- BCC is important in communicating to people in the use of FP as per the patcha study. Contraceptives should be included in all HIV/AIDS treatment centers with the introduction of the fertility sexuality assessment tool.
- Body mapping is a good approach to allaying fears by clarifying although the appropriate tools need to be developed into programs.

SESSION B04: ASSESSING THE COSTS AND BENEFITS OF PROVIDING SEXUAL AND REPRODUCTIVE CARE

Chairs: Elizabeth Lule Laura, World Bank

Presentations

Paper 1: The Benefits of Meeting the Contraceptive Needs of Women in the Philippines
Presenter: Dr. Michael Vlassoff, Guttmacher Institute, USA

Summary of Presentation
In this study, Dr. Michael Vlassoff assessed the benefits of meeting the contraceptive needs of women in Philippines. This was aimed at helping policy makers improve Maternal and Child Health and to estimate
the cost – benefit of Contraceptive Prevalence Rate use. The study targeted the risky group, in particular the sexually active, fecund, those who do not want another child some time or for ever. Demographic and Health Survey and Census were the sources of data. Five scenarios were assessed: cost and benefit of providing no contraceptives; current level of contraceptive use; providing method mix; satisfying half the current unmet need for contraception; satisfying all current unmet need for contraceptives. The results revealed that, women not using contraception accounted for 9 in 10, contributing to significant unwanted pregnancies. Among the women using contraceptives, abortions and unplanned pregnancies decreased across all the five scenarios. Contraceptive use protects health (reduces maternal deaths annually) and improving maternal health saves money on Maternal and Child Health programs.

Paper 2: The Benefit of Meeting Contraceptive Needs of Women in Uganda and Ethiopia
Presenter: Dr. Fredrick Mugisha, Economic Policy Research Centre
Summary of Presentation
This study established the costs and benefits of contraceptive use in terms of health and medical costs. In this study, four scenarios were assessed: cost and benefit of providing no contraceptives; current level of contraceptive use; satisfying half the current unmet need for contraception; satisfying all current unmet need for contraceptives. The findings revealed that modern Family Planning methods reduced abortion and unplanned pregnancies. Modern Family Planning averts maternal mortality and maternal Disability Adjusted Life Years (DALYs). For example, in Uganda, satisfying all (100%) of current unmet need for contraceptives would avert an estimated 3,300 women dying per annum and reduce maternal DALYs by 211,000; in Ethiopia, this would avert an estimated 6,674 women dying per annum and reduce maternal DALYs by 549,000. Expanding modern contraception narrows the gap between the poor and the rich/wealthy and save money for the health care. The findings in this study were similar to those in the Philippines. Investing in Family Planning programs contributes to real benefits (health and money). This calls for stakeholders support to ensure a reliable contraceptive supply chain.

Paper 3: The Human and Economic Impact of RH Supplies Shortage and Stock Outs in Bangladesh
Presenter: Prof. Abul Brkat, IPPF United Kingdom
Summary of Presentation
The study investigated the impact of stock outs, shortages, and irregular supply of pills, DMPA and condoms at household level and to the national governments. The study cost suffering and lost time due to stock outs, shortages, and irregular supply of pills, DMPA and condoms. The finding revealed that the household loss of income due suffering (physical, psychological, time lost due to inability to participate in income generating, social, household activities) as a result of stock outs, shortages, and irregular supply of pills, DMPA and condoms for 1 year was estimated at $ 15million at the national level the cost to the national economy was 4,275 hours translating to $4870 million. Pregnancy suffering included unexpected pregnancies, unintended childbirths (results into abortions, MMR, still births).

Discussion
The fact that investing in Family Planning programs saves money generated huge interests. For example in terms of time frame, when is this saving coming through (how soon is it?). The presenter explained that these were short term not long term savings. For example, in Uganda, the vote for Family Planning programs by Ministry of Finance Planning and Economic Development has stagnated for the last 10 years. People understand the benefits of investing in Family Planning; however this understanding has not been translated into actions, advocacy and resource mobilization including leadership commitment at various levels.

Responding to a concern about the extent to which the World Bank can improve contraceptive procurement system, the chair explained that strengthening the system for international competitive bidding, building the capacity of ministries to do the tendering process and technical specification including forecasting and self – life. Responding to the cost – effectiveness for demand – supply for the poor, the presenter explained that reducing the unmet need markedly accrues befits, but also investing money should go hand in hand with strengthening systems.
Key Recommendations

Sufferings as a result of stock outs, shortages, and irregular supply of contraceptives reverses economic gains and growth. It was recommended that advocacy for Family Planning need to be packaged in a multisectoral approach (benefits of investing in Family Planning programs and consequences of not investing in Family Planning programs).

SESSION C04: PSYCHO-SOCIAL ASPECTS OF FP II

Moderator(s): Janine Barden O’Fallon, Measure Evaluation, USA; Marsden Solomon, Family Health International, Kenya

Presentations

Presentation 1: Contraceptive Practice Prior to Female Sterilization in Ghana: 1996-2006
Presenter: Hilary Schwandt, Johns Hopkins Bloomberg School of Public Health

Presentation Summary
Ghana has experienced a decline in TFR (from 6.5 to 4), yet maintains a low CPR. While modern methods increased from 1988-2003, female sterilization was a small percentage of the total contraception. The study targeted women who had used contraception before their sterilizations. 40% of the sample had at least one abortion, and just over half had used modern methods before sterilization. Most women found out about sterilization from their clinicians, and over time, the percentage of women that learned about sterilization from a spouse decreased, while the percentage that learned about sterilization from the media increased. The presenter recommends that women should consider using modern contraception before sterilization.

Presentation 2: “Pages of Life”- Research on the Impact of Social Merchandising
Presenter: Scott Connolly, Population Media Center

Presentation Summary
The aim of the project was to monitor telenovelas in Brazil and work with the media for education and social benefit. The research team recognizes the opportunity for “parasocial interactions,” when characters exhibit health behaviors, it can lead to vicarious learning by the audience, and eventually lead to accepted attitude and behavior change. The telenovelas can address timely social issues, such as recent deforestation of Brazil’s rainforests. Sexual and reproductive health, family planning, and HIV/AIDS have been hot topics in Brazilian telenovelas. The research team conducted structured interviews to measure the impact of telenovelas on knowledge, attitudes, and behaviors relating to family planning and reproductive health. More than half of women sampled at reproductive health clinics state that the telenovela motivated them to seek services. Results showed that the telenovela increased health knowledge about reproductive health and unwanted pregnancies. The presenter commented that it was difficult to measure the results due to several factors, including no baseline data.

Presentation 3: Finding the Right Messages about the IUD
Presenter: Claire Stokes, PSI Tanzania

Presentation Summary
The project aim was to promote long-term methods, especially the IUD, and to determine the most effective messages for potential users. The researchers conducted both a qualitative and quantitative study that explored the determinants of family planning and decision-making behavior associated with the IUD. The qualitative portion of the study included in-depth interviews and photo narratives that explored attitudes and knowledge, such as IUD safety, the drawbacks in comparison to other methods, and factual information. The quantitative portion of the study explored levels and trends in behavior, behavioral determinants, and exposure to social marketing campaigns. Results showed that women were in favor of the fact that the IUD does not interfere with sex. The research team developed a profile of the target audience, including their likes, dislikes, and habits. This “audience profile woman” is leadership-focused and emphasizes future success. The messages that focus on safety, method effectiveness, and ease
was integrated at health centers, where many women receive their family planning knowledge. As a result of this research and intervention, IUD insertion increased over a period of seven months.

**Presentation 4:** Influence of Independent and Proximate Variables in Predicting Ever-use, Current-use, and Use of Condom During Last Sex in Nigeria  
**Presenter:** Akanni Ibukun Akinyemi, Obafemi Awolowo University, Nigeria  
**Presentation Summary**  
Nigeria has high rates of maternal and child mortality, high rates of youth pregnancy (especially among rural girls), and low control over birth spacing and timing. The presenter also drew attention to the commonality of sex being exchanged for gifts and/or money. The project used secondary data analysis to measure ever, current, and use during last sex in relation to gender, age, religion, and other determinants. Results showed that the highest risk group is rural Evangelists. Older and more educated people were more likely to report ever use of condoms. The presenter reported difficulty with the vocabulary comprehension of “ever use” and “current use” of condoms.

**Presentation 5:** Social Change to Increase Family Planning Use- Strategies and Impact Documentation  
**Presenter:** Marcie Rubardt, CARE USA  
**Presentation Summary**  
The program aimed to employ the use of the Social Analysis and Action approach to improve family planning uptake in Kenya, Ethiopia, and Rwanda. Baseline data collection included qualitative and quantitative household surveys in an effort to understand the community’s social dynamics. It also included social mapping, in which community members drew maps of the community and its resources, and pile sorting, in which community members distinguished the characteristics and roles of the two genders. Findings showed a significant desire for large families, a preference for sons, and a trend for mistimed pregnancy and unmet need. Social norms lagged behind individual views. For instance, more people cited the economy as a reason to have smaller families. There was a blatant disagreement regarding the issue of family planning among unmarried girls. It seemed to be an issue that exists, but is largely ignored. The study showed that special distinct strategies are required to reach men and women. The presenter commented that citing “myths and misinformation” as a barrier gives people an excuse not to use family planning, but they may actually know better.

**Discussion**

The audience asked the first presenter about the relationship between the presentation and the session topic (psycho-social aspects of family planning), and if abortion could explain the trend of high unmet need but lower fertility. The presenter responded that the subjects were not asked why they had been sterilized or why they had chosen to use or not use contraception. The presenter agreed that abortion could make up for the gap between the CPR and the fertility rate.

For the fourth presentation, the audience questioned the presenter about the condom use indicator. Did it include female condom use when questioning females? The presenter responded that the survey did not include female condoms, but as a female, did their male partner use a condom?

The audience asked the last presenter about the relationship between gender norms and family planning, and if there is a strategy to change gender norms by improving access to family planning. The presenter responded that gender and family planning are certainly linked. In order to improve gender dynamics, community-based interventions are important, but it is also important to have clinical interventions. Women need to be treated with respect in the clinical setting to begin to improve gender dynamics.

**Key Recommendations**

Social merchandising, as part of an integrated system, can have positive impacts on attitude and behavior change. Different strategies are necessary to reach men and women in family planning. Both community and clinical interventions are necessary to improve gender dynamics in relation to family planning.
SESSION D04: INTEGRATING FP AND HIV PROGRAMS III

*Moderator(s):* Manjula Lusti-Narasimhan, World Health Organization, Switzerland; Grace Nagendi, Engenderhealth, USA

**Presentations**

**Presentation 1:** Contraception Continuation and Initiation by Newly Diagnosed HIV-infected Women in Malawi.

**Presenter:** Gretchen Sauer Stuart, University of North Carolina Chapel Hill, United States of America

**Summary of Presentation**
In Malawi where HIV prevalence is 11 -17% and unintended pregnancy is 40% understanding best practices for contraceptive management in HIV+ women is crucial to save lives of women and their families. This study estimated the probability of contraceptive continuation and initiation in a group of women from an urban setting in Lilongwe, who had just received their HIV+ status results. Data for this study was collected as part of a fertility intentions study undertaken from December 2003 through January 2005. The presenter with the help of Kaplan-Meier plots showed estimates of probability of initiation and continuation of contraception over the study follow-up period. The probability of initiating contraception among the women with a stated intent to use contraception was 0.68, suggesting that for many, their actions did indeed match their intent. Women using injectables at the time of enrollment had a 0.61 probability of still using injectables at the final 12 months study visit. The presenter stressed that estimates were done on only injectables and oral contraceptives because the numbers of women using the other methods were too small. When continuation was then stratified by site the highest probability of continuation was among women who were recruited from the family planning clinic and the lowest probability among the women recruited from the sexually transmitted infection clinic.

**Presentation 2:** Improving Integration of Family Planning into ART Services: Experiences from Development of a Provider Orientation Package (OP)

**Presenter:** Solomon Marsden, Family Health International, Kenya

**Summary of Presentation**
The presenter described their experiences from the development of a package for ART service providers in the provision of FP services in Kenya. The presenter declared that a formative research conducted in 2007 to understand fertility intentions of HIV-positive clients at a Provincial General Hospital in Kenya revealed that there was more than 25% unmet need for FP. Since HIV-positive clients access clinics for services such as ARVs, adherence counseling, treatment monitoring, and psychosocial support, these will be a good avenue for FP services as clients usually make several repeat visits to these centers. To assess the feasibility of this idea, a task force developed an OP of FP-HIV integration. Forty trainer of trainers were trained on the OP and field testing done. Through the project, HIV-counseling and testing services at the provincial level and selected district level facilities are now able to provide comprehensive FP services including screening for fertility intentions of clients. The presenter indicated that the Kenyan Ministry of Health remains committed to this. The pressure to finalize the training material to meet the demand for the update from programs/service providers, however, posed a challenge to the team. The presenter concluded that, the initial step has been taken which is the development of the OP, and that scale up of the FP/ART services need to be carried out while developing standardized tools for capturing FP/ART services.

**Presentation 3:** Integrating HIV and Family Planning Services: Are Providers Ready?

**Presenter:** Susan Patricia Enea Adamchak, Family Health International, United States of America

**Summary of Presentation**
This study looked at the preparedness of clinics and service providers to provide services to women in need of FP or HIV services, the level of integrated service provision, including counseling and provider-supplied contraceptive methods, and the availability of service data that can be used to monitor service
integration. The assessment was done of programs, clinics, managers, providers, clients in five countries – Ethiopia, Kenya, Rwanda, Uganda, and South Africa. In all 20 programs from public sector, private sector, and NGOs were used. To assess whether VCT providers were prepared for FP service delivery, provider designation, training, integration guidelines, an availability of job aids were assessed. The presenter provided data to show that a wide variety of methods were offered by FP providers that offered HIV services. With respect to provider attitude toward condom use, the presenter lamented that most providers see condoms as a means to prevent transmission in clients who were already infected but not as a tool for primary prevention. The key messages from the presentation were that even though systems are moving forward to provide integrated services, providers are not fully prepared as evidenced by the lack of training, job aids, and awareness of guidelines. Most counseling and testing providers lacked the necessary FP training, and only limited FP counseling was being done by providers. The presenter called for the need for providers to be updated with information about appropriate FP options for HIV+ women.

**Presentation 4:** Providing Family Planning in Ethiopian Voluntary HIV Counseling and Testing Facilities: Client, Counselor and Facility-level Considerations  
**Presenter:** Heather Bradley, Johns Hopkins Bloomberg School of Public Health, United States of America

**Summary of Presentation**
Between 2004 and 2008 in Ethiopia, VCT facilities increased from over 600 to nearly 1500 with a corresponding increase in the number of HIV tests. Premised on the rationale that VCT centers may be a good venue for offering family planning services, the Ethiopian government passed a policy that was launched in 2004 to promote HIV and FP integration. This research estimated the need and demand for FP among VCT clients in eight public sector facilities in Ethiopia. It also assessed clients’ contraceptive uptake in VCT sessions. To examine what would happen when quality family planning services are added to VCT sessions, the researchers initiated a cross-sectional study, pre- and post-intervention (before and after family planning services were made available in VCT counseling sessions). The presenter provided data that showed that contraceptive use increased substantially between the pre-intervention and post-intervention surveys. She, however, stressed that these were methods clients were already using when they presented at the VCT clinic. The presenter added that this probably reflects the increasing contraceptive prevalence in the client population rather than an effect of the intervention. With respect to study impact outcomes, the presenter mentioned that there was a major improvement in contraceptive counseling from baseline to endline.

**Presentation 5:** The Effect of VCT Acceptance and Uptake of Antiretroviral Treatment on Modern Contraceptive Use Among Women in Rakai, Uganda.  
**Presenter:** Fredrick E Makumbi, Makerere University School of Public Health, Uganda

**Summary of Presentation**
While knowledge of contraceptives is almost universal in some settings, fertility in SSA is high. In Uganda for instance, modern contraceptive use is low among HIV+ women. The presenter speaking on behalf of his co-investigators indicated that, their study assessed the effect of VCT uptake and enrolment into ART/HIV care on use of modern contraceptives and condoms for family planning among women aged 15-49 years in Rakai, Uganda. Tapping into a population-based cohort in 50 rural villages in Rakai initiated in 1994, they conducted a detailed survey, with individual interviews and blood for HIV testing. They also collected information on pregnancy status, fertility desires, use of FP methods, receipt of HIV test results among others. The presenter indicated that the majority of the women had ever received HIV test. Use of condoms-only was more common in the unmarried compared to the married, and use of modern methods which included condom was more common in married compared to unmarried. VCT without result discussion was associated with higher use of modern methods VCT and HIV+ status were associated with higher use of condoms but not modern methods. Being in HIV care is strongly associated with higher use of condoms for FP. Overall, modern contraceptive was more common among unmarried. Strategies that address desire for high fertility need to developed or strengthened.

**Discussion**
The discussion on this session was opened with commendatory messages to the presenter who shared the Kenyan experience on the development of a provider orientation package. An audience commented that, the program seemed to have been so successful that, he doesn’t understand why it has still not been scaled up throughout Kenya and beyond. The presenter in commenting back said that it is true that service providers as a result of the project now feel confident providing the services, and clients believe they are getting both services at the same time, which is good for them. The presenter added that the steps to scale up are carefully being considered, so is the development of standardized tools for capturing FP/ART services. Reacting to his suggestion on addressing the desire for high fertility, the presenter from Makerere University reaffirmed his suggestion that, it can be attained by continued health education, and correction of common misconceptions on use of modern contraceptives. The presenter particularly lamented on the misconceptions that modern contraceptive use among HIV+ people is problematic even after data from FHI had shown that oral contraceptives are not contra-indicated in this category of users. Reacting to a comment on the gaps their research identified the third presenter …….. they have done a number of things to address these gaps. First dissemination events have been held in three of the five countries where their assessments were done. This she said were very well attended. Unfortunately, they haven’t made any follow since then to see if the responsible authorities have taken up their recommendations. A summary of their message is currently being prepared. This will be shared with all the responsible authorities. She also added that the summary could be downloaded from the website of FHI – www.fhi.org.

Key Recommendations

Future research should report outcomes for all integrated health areas and should investigate client and community member perspectives. Longitudinal research is needed to examine not only FP acceptance but also use or continuation. Offering family planning in VCT may be an effective strategy for reaching high-risk clients who need both service types. VCT receipt, especially among HIV+, and HIV care programs can increase contraceptive use especially condoms, but more needs to be done to increase the modern methods. High fertility desires still significantly determine contraceptive use in this rural setting, strategies to address desire for high fertility therefore need to be developed or strengthened.

SESSION E04: HORMONAL CONTRACEPTION AND HIV

Sponsor: Family Health International

Presentations

Paper 1: Hormonal Contraception and HIV-1 Infectivity: An Overview
Presenter: Ludo Lavreys; Jared Baeten, University of Washington, United States of America

Summary of Presentation
The presenter observed that hormonal contraception increases a woman’s risk for acquiring sexually transmitted infections, particularly Chlamydia trachomatis. The presenter also noted that studies of contraceptive use and HIV-1 shedding among women taking antiretroviral therapy should be a priority among health providers. The presenter said that there is a high unmet need of family planning services of 25% globally and that there were both direct and indirect impacts of genital HIV-1 on human beings. Recent evidence in USA suggests inconsistent results in the risk for cervical however adherence is a primary predictor of infectivity. The presenter finally recommends further studies among HIV-1 serodiscondant couples would offer the best opportunity to directly measure the true effects of contraceptive use on HIV-1 infectiousness.

Paper 2: An Overview of Hormonal Contraception and HIV Disease Progression
Presenter: Elizabeth. M. Stringer, University of Alabama at Birmingham, United States of America

Summary of Presentation
The presenter noted that almost 15 million women are infected with HIV/AIDS worldwide and that women infected with HIV need access to safe and effective contraception, just as uninfected women do. The
presenter said that recent animal and human data suggest that hormonal contraception may affect HIV-1 progression. However, existing studies are in conflict on the impact of hormonal contraception on HIV disease progression. Further investigation into the effect of hormonal contraception on HIV-1 disease progression is a matter of particular urgency. The presenter studied contraceptive IUD devices in Zambia on women whose CD4 count had fallen below 200 cells with an intention to treat analysis.

Paper 3: Hormonal Contraception and HIV Acquisition
Presenter: Charlie Morrison, Family Health International
Summary of Presentation
Hormonal contraception is used by over 150 million women worldwide, including over 100 million women who use Combined Oral contraceptives (COC) and over 50 million who use the injectable progestin depo-medroxyprogesterone acetate (DMPA). The objective was to review the evidence on the relationship between hormonal contraceptive use, especially COC and DMPA use, and HIV acquisition among women in general and among young women (<25 years) in particular. The presenter noted that research conducted among Macaques suggested that use of progestin-only contraception, in particular DMPA, increased the risk of simian immunodeficiency virus (SIV) acquisition. Additional research was urgently needed to understand the effect of hormonal contraceptive use on HIV risk among young women. The presenter said there was a high unmet need for family planning in Kenya, at an estimated at 60%. The presenter cited that WHO guidance on family planning is updated regularly and that it concerns MDGs 4, 5 and 6. The presenter finally concluded that family planning saves lives and that hormonal contraception remains a safe option for all women and those with HIV/AIDS.

Presenters: Wolfgang Hladik, CDC Uganda
Summary of Presentation
The presenter enumerated the contribution of family planning in the prevention of mother to child transmission of HIV/AIDS. The presenter compared the effects of ARVs prophylaxis for the prevention of mother-to-child HIV transmission (PMTCT) to that of existing family planning use and estimated the burden of pediatric HIV disease due to unwanted fertility. The presenter used the demographic software spectrum, a baseline mathematical projection, to estimate the current pediatric HIV burden in Uganda in comparison to the hypothetical situation without ARV-PMTCT, without contraception, and without unwanted fertility. The presenter noted that the HIV prevalence curve from the Ministry of Health of Uganda was expected to remain stable from 2005 to 2012. The presenter recommended breast feeding for at least 1-8 months and concluded that existing family planning use contributes as much as or more than ARV-PMTCT in mitigating pediatric HIV infection in Uganda.

Discussion
Professor Elizabeth Stringer was asked whether women in Zambia preferred switching methods of family planning. She said they had considered switching methods of family planning and they used both combined pills and injectables. Doctor Lizungu asked whether estrogen was different from pills and Professor Stringer said that estrogen was a hormone while pills were contraceptives. Professor Martin said that there was inadequate contraceptives in rural areas in line with the question asked by the moderator who asked why rural women use less contraceptives. He said that information was not widely available in Kenya, and that they tried to train service providers. The moderator said that the recommendations raised should be looked at by the World Health Organization. A member from the audience asked whether emergency contraceptives posed a threat to HIV positive women, which was left unanswered due to insufficient time.

Key Recommendations
Expanding family planning services can substantially contribute towards PMTCT. The audience agreed to stop rigidity in using hormonal contraceptives. Young people need focused contraceptives which suit their lifestyle. Most resort to the use of condoms since they do not have any other contraceptives. The
audience unanimously agreed that there was no need for any change in contraception policy. HIV infected women should use condoms to reduce reinfection from their partners.

SESSION F04: EFFECTIVENESS OF COMMUNITY-BASED DISTRIBUTION

Session Chair: Nancy Pendarvis Harris; Wilfred David Ochan

Presentations

Paper 1: Improving Family Planning Utilization by Repositioning Family Planning /Reproductive Health Program through Strengthening Community-based Health Service Extension Program (HSEP) in Ethiopia

Presenter: Dereje Ayele, Ethiopia Public Health Association

Summary of Presentation

The presenter explained that the paper is based on what the program has done and observed, and not on statistics and hypothesis. The background information about Ethiopia showed that the country still experiences high mortality, morbidity, fertility rates. With 73.9 million people, Ethiopia is next to Nigeria in terms of a population on the African continent. The presenter noted that CPR has increased from 8.1% in 2000 to 14.7% in 2005 but observed that this is still low. Poor health service delivery is common, but the Ethiopian Government has endeavored to improve this state and reach rural underserved populations with family planning services through abolishing taxes for family planning products, engaging the private sector and NGOs, and linking family planning with other health services such as HIV/AIDS. The HSEP program started in 2004 in the Northern part of the country, covering 524 villages and aimed to strengthen family planning services through improving knowledge, skills and practices of 1,566 Health Extension Workers. A baseline survey helped establish the gaps and this was followed by key activities, including training at all levels including health services managers, joint support supervision, and awareness creation using IEC materials. As a result of the program, there is increased demand for long term methods, sharing of resources among partners has reduced duplication, and family planning has been integrated into other services. A newsletter was established to share important updates has been taken up by the Ministry of Health. The presenter emphasized that the Ethiopia Public Health Association is not the implementer but coordinates the effort where different players find it conducive to work together. The HSEP is an example of a successful innovative collaborative model that has created an enabling environment for increased access and utilization of family planning services in a rural setting.


Presenter: Lisa M. Basalla, University of North Carolina, United States of America

Summary of Presentation

The presenter noted that as the unmet need for family planning has increasingly become an obstacle to achieving MDGs, a multi-institution team reviewed existing literature on family planning interventions stretching from 1994 to 2009. The purpose was to synthesize information about family planning programs research and evaluations to determine the current state of affairs, gather information on effective family planning programs to inform scaling up efforts, and make recommendations about future research on family planning. On methodology, an inclusion criteria was adopted including experimental and non-experimental designs and this was followed by categorization of the articles/research reports. In summary; 9 articles on BCC and mass media programs, 26 on Interpersonal Communication, 5 on development approaches, 9 on access of family planning services, 8 on quality of care and 1 study on cost analysis of an outreach program were created. Limitations included difficult to compare studies, not all components of the programs were evaluated, publication bias i.e. tendency to include in the reports only positive results, English and French were the only languages used, and some were unpublished reports. The presenter outlined future action points as undertaking evaluations of family planning interventions, determining feasibility of scaling up small effective family planning programs, evaluation of long-term impact of programs, and examining impact differentials among varying target audiences such as urban poor vs. rural poor.

Presenter: Angela Akol, Family International, Uganda

Summary of Presentation
The presenter described Uganda as a country with a very high fertility rate and low utilization of modern contraceptives (24%). Uganda has a very high unmet need at 41% and for Injectables, it is estimated to be 50%. Uganda is facing a shortage of trained health workers, which has further complicated delivery of family planning services, particularly in rural areas. With endorsement from the Ministry of Health and in consultation with WHO, Family Health International (FHI) supported a pilot (Dec 2007-Dec 2008) of two public sector and two non-governmental CBD programs that introduced injectables (Depo Provera) at the community level. The purpose of the pilot was to document better evidence to justify the scaling up of Injectable contraceptives at the community level. It was a targeted process whereby those districts and NGOs already implementing family planning services were considered, while building on the existing logistics procurement and support supervision systems. Results from the pilot show that the impact of the program in both the public and NGO sector is comparable: Community Health Workers (CHWs) in the public sector over six months provided 10 years of protection to couples while CHWs in the private sector provided 7 years of protection. Also, Community-Based Distributors (CBDs) can play an important role to increase access and utilization of injectable contraceptives even among new users as noted from the pilot, 57% were new users. Finally, CBDs can increase acceptability and continued use of new family planning methods. The presenter mentioned that 92% of women returned for re-injection and safety was guaranteed as 0% of needle-related injuries were reported. Now that there is evidence, the presenter strongly recommended that the Ministry of Health and partners should support scaling-up of community-based injectables to maximize access to contraception in Africa. Ethiopia and Madagascar were mentioned as other countries in the process of initiating community-based injectables. One key lesson is that to ensure sustainability, the private sector needs to work with and integrate their activities into the public sector. In this paper the term private sector and NGO are used interchangeably.

Paper 4: Findings from a Qualitative Study of a Pilot Community-Based Distribution of DMPA Program.

Presenter: Connie Alezuyo on behalf of Laura Ehrlich, Minnesota International Health Volunteers.

Summary of Presentation
Minnesota International Health Volunteers (MIHV) is implementing community-based family planning programs in two districts of central Uganda. During 2008, MIHV in order to increase method mix, piloted a community-based DMPA program in Mubende District. Family Planning Community-Based Health Workers (FPCHWs) were trained and dispensed 870 units of DMPA thus providing 217.5 years of protection in the first 10 months. The qualitative study interviewed 19 key informants and 13 individuals in the Focus Group Discussion. The presenter mentioned key findings from the pilot as high client satisfaction; increased access and convenience with confidentiality assured, especially to women who didn’t want their male partners to know that they were using family planning; high quality service and safety characterized by one-on-one counseling; client follow-up using a mobile phone reminders; demonstration to assure clients that the method was properly sealed and not expired; and adequate injection hygiene. Challenges recorded include a limited number of FPCHWs to reach a wide area, inconsistencies in supply of DMPA, transport challenges by FPCHWs to the health facilities, demotivation of FPCHW not selected for CBD of DMPA, some myths and misconceptions like a belief that injectables can cause infertility, and low male involvement. Integration of the program into district health programs is critical for continued technical support, supervision of FPCHWs, and continuity. The presenter recommended more focus on Behavior Change Communication around partner disclosure of family planning use.

Discussion
It was generally observed that community-based distribution of contraceptives (CBD) as an approach has taken a low profile over the last decade and thus as family planning programs are being revitalized, it needs to be re-visited and repositioned to tap into its strengths in scaling up national programs. The chair mentioned that community based distribution is a tested approach with over 30 years of proven effectiveness in Zimbabwe and advised that the current pilots should move rapidly to the expansion
stage. However, in the interest of integrating family planning into existing programs and community structures, one participant suggested that family planning CBDs shouldn't be considered solely for family planning but should be viewed as Community Health Workers who can deliver other services to the community such as malaria control, HIV etc. The Ethiopia community-based Health Service Extension Program (HSEP) experience was appreciated as an ideal example where community-based health workers are integrated in service delivery; work in partnership with private sector, government and NGOs to deliver their services.

The presentation by Family Health International that volunteers are able to do impressive work without any form of payment motivation generated many queries. In response the presenter said community recognition is the main form of motivation and to confirm this, there are almost no drop-outs. But this seemed not so convincing and no concrete explanation was provided about what keeps volunteers motivated. The presenter observed that there is need to take a comprehensive study on volunteerism and motivation of community health workers to guide community-based programs better.

Participants wanted to know whether the programs faced the challenge of shortages of commodities and high operation costs and how these issues were being addressed. In the case of Ethiopia, the program has not faced shortages and the presenter attributed this to strong collaboration with Government, private sector, and NGO partners who have fully embraced the program and want it to succeed. In the case of Uganda, stock outs of family planning commodities was reported and addressed by districts borrowing from their neighboring districts, but in the long run, the presenter advised that districts need to increase budget allocations for timely procurement of family planning commodities and to meet operational costs. The presenter from FHI-Uganda clarified that since implementation of the program built on the existing health facility and community structures, the operational costs have been minimal.

Since injectables are a method requiring injecting clients, participants wanted to know whether authorization was first obtained from the Ministry of Health, how the programs were monitoring community-based Health Workers to ensure they don't participate in injecting against other diseases, and how waste is managed at the community. In the case of Uganda, the Ministry of Health was involved in planning the pilot and authorizing the community health workers to use the injection method. To ensure CHWs had the necessary skills and for safety precautions, they were trained for two days. Regarding disposal of wastes, CHWs are provided with a trash box which they take to the health facility when full for proper disposal. About guarding against misuse of injections, the injections are taken strictly on the arm whereas for other diseases it is always on the buttocks. In addition, they are accountable to the community which polices them.

It was observed that all programs are grappling with a challenge of myths and misconceptions about family planning methods in general and injections in particular which they associate with side effects like over-breeding and the thought that it can cause infertility. This challenge in the case of Uganda programs is being addressed through focused counseling sessions by sharing simplified key messages to address specific problems that users may encounter and referring to health facilities for further support.

In appreciation of the fact that male involvement in FP is currently limited, a participant wanted to know why only females and not males were involved in the community family planning program in Ethiopia. In response, the presenter clarified that women are preferred because at the household level, women know fellow women better and can serve them better. In addition, this is supported by the Ethiopian government because it benefits women, but men are also involved at the community-level awareness creation for their support.

**Key Recommendations**

Collaborative approach between government, private sector and Civil Society Organizations creates an enabling environment for increased access and utilization of FP services, particularly among underserved populations. There is need to undertake big scale Impact Evaluation Studies of FP/SRH programs to document and share factors for their success to guide scale up of effective approaches. To increase
uptake and sustain utilization of FP services, Behavior Change Communication (BCC) around partner
disclosure of FP use and dispelling myths/misconceptions of FP methods is very important. Community-
Based Distribution approaches have been tested over the years to be effective and should be utilized in
taking to scale the current community-based Injectables programs to reduce high unmet need.
Community-based Health Workers are key to the success of FP/SRH programs. To sustain their interest, there is need to undertake a comprehensive study on volunteerism to better guide community based FP/SRH programs.

17 NOVEMBER 2009 – PLENARY

Session Chair: Michael Holscher, Marie Stopes International

The plenary chair, Michael Holscher, introduced the session with three key messages: 1) Evidence exists for what works in family planning; 2) Family planning is a critical part of maternal health and should not be ignored; and 3) More donors and governments are needed to fund what works and not just what is expedient.


Baroness Jenny Tonge, United Kingdom House of Parliament

The all-party group for Population, Development and Health in the UK House of Parliament produced the report “Return of the Population Factor” two years ago, which states that the MDGs will not be reached unless global population growth is curbed. Baronness Tonge stated that this year, finance ministers are taking the messages presented in the report seriously to scale. Shock tactics are being employed, and they are bringing attention to permanent disfigurations from fistula; prolapsed uterus; unsafe abortion; hemorrhage (easy drugs exist); infections; preeclampsia and eclampsia (easy and cheap treatment available); anemia from prolonged childbearing; and mental health disorders.

Unmet need for family planning is causing all of these problems, and Baronness Tonge boldly stated that all this suffering can be prevented if women were valued more. After all, cheap and easy drugs exist and birth attendants can be trained on simple remedies. More funding is needed to address these issues as well as changing country laws, like abolishing child marriage, decriminalizing abortion, stopping female genital mutilation, and stopping the Roman Catholic Church and others interfering with women’s health. The report can be found on the website: www.appg-popdevrh.org.uk.

UNFPA Call for Action: Reducing Inequities in Family Planning Access

Nuriye Ortayli, UNFPA

National statistics often hide disparities between different groups with regard to unmet need and contraceptive prevalence. UNFPA more closely examined the problem of inequities—between different regional groups, between countries, and between urban and rural regions within countries, and between age categories—and the interventions used to overcome the inequities to produce the report “Recommendations for Action for Reducing Inequities” (distributed in conference packets).

The report emphasized the necessity of multisectoral interventions and putting family planning and sexual reproductive health at the core of universal basic health services. More emphasis is also put on health systems strengthening and primary health services.

Ms. Ortayli stated that while UNFPA developed these recommendations, there needs to be wider agreement and collaboration for implementation. UNFPA hopes that this report is a starting point for discussion, and partners, donors and civil society to will lend their support to the recommendations set out in the report.
Ms. Kanyoro recounted a personal story from her childhood friend that had died from unsafe abortion, emphasizing that stigmatization on sexual topics and sexuality made the incident more horrible. This same stigmatization affects the continent of Africa.

The Packard Foundation believes rapid population growth affects the dignity of people, and therefore its program strategies are grounded in ICPD 1994—ICPD 1994 is the basis for its population, SRH and family planning programs. The Foundation supports organizations that are willing to take risks and respond to realities on the ground. It plays an active role in the capacity building of nongovernmental organizations. The Foundation tries to play a mentoring role to its grantees through consultants and advisors. Furthermore, it listens to their grantees when developing their strategies.

In Africa, the Foundation has programs in Nigeria and Ethiopia. These two countries showcase how misinformation about contraceptives can hinder achievements in family planning. Through community-based programs in the two countries, the Foundation supports organizations that popularize information to young people and to women and men who can help destigmatize certain contraceptive methods.

The Foundation focuses girls between 12-19 years of age, as this is age when women begin making decisions. It supports organization that can mobilize other resources and mobilizing leaders. It also supports grantees working on controversial issues, like making abortions safer or on postabortion services. Going forward the Foundation will focus on two new areas: 1) Using the power of women’s voices in leadership to carry message of family planning; and 2) Concentrating on the girls 12-19 years of age and supporting their education as well as social and economic empowerment.

**The Maputo Programme of Action: Where Is It and What Evidence is Still Needed?**

**Tewodros Melese, International Planned Parenthood Federation- Africa Regional Office**

The Africa Regional Office of the International Planned Parenthood Federation and its associate offices led the Continental Policy Framework on Sexual and Reproductive Health and subsequent Maputo Programme of Action. The Maputo Plan of Action is a commitment by African leaders to advance reproductive health as a priority development issue. It aims to have universal access to comprehensive reproductive health and rights by 2015 and has the following seven strategic areas: 1) Integrating sexual and reproductive health, HIV/AIDS, STIs into primary health care; 2) Repositioning family planning; 3) Providing youth friendly services; 4) Reducing unsafe abortion; 5) Ensuring safe motherhood; 6) Ensuring commodity security; and 7) Ensuring monitoring and evaluation.

The Maputo Plan of Action builds on previous notable agreements and declarations and contains goals, objectives, timelines, indicators and targets. A priority in the Plan is that national budgets contribute to MDGs and states that 15% of national budgets be dedicated to the Maputo Plan of Action.

The Maputo Plan of Action is significant because it is an African initiative lending to ownership by member states. It was developed through participatory processes within a wide cross-section of stakeholders, policymakers, and civil society members. The Plan is inclusive and clearly spells role of all stakeholders. Finally, it engenders the African Commission to mobilize resources and the East African commission to provide technical assistance. Member states have been give the directive to mobilize resources and implement the plan.

The Plan has a two-pronged approach. First, at a regional level it advocates for implementation of the plan and for increases in budgetary allocation for reproductive health. These are done at regional forums such as health minister’s meetings, policy dialogues with stakeholders, and with regional economic communities (such as the East African community, legislative assemblies; and economic blocks).
Secondly, at the country level, existing networks are utilized to implement the Plan of Action and constant policy dialogues are maintained with parliamentarians.

17 NOVEMBER 2009 – CONCURRENT SESSIONS

SESSION A05: NEGLECTED FAMILY PLANNING ISSUES

Moderator(s): Maureen Kuyoh, Family Health International, Kenya; Valerie De Fillipo, IPPF, UK

Presentations

Paper 1: The Stalled Fertility Transitions and Family Planning in Kenya
Presenter: Ian David Askew, Population Council, Kenya
Presentation summary
The presenter explained that Kenya was one of the first countries in Africa to have a population policy in the 1960 and this led to tremendous success in fertility. Fertility halved in the early 90's and CPR increased. Although this was the case in mid 90’s to 2003 things changed, the fertility stalled at some point and slowed in increase and this was attributed to the diluting focus in family planning issues and also political tensions, economic decline and increase in infant mortality rate. These changes were noticed most in least educated and also in the poor populations. The presenter explained that several lessons can be learned form this stalling and slow increase in population in Kenya some of the include need for focus in awareness of the available methods and their sources to the poor populations which contributes to half of the countries population, need to involve the private sector as the source of contraceptives, need to create demand for family planning, integration of family planning in MCH and HIV and also need to reach the adolescents.

Paper 2: Family Planning in Sub Saharan Africa: Progress or Stagnation?
Presenter: Robert Peter Ndungwa, London School of Hygiene and Tropical medicine.
Presentation summary
The presenter explained that fertility transitions in Sub-Sahara Africa appeared to have slowed down and the aim of the analysis was to see the progress in the fertility in this region as to whether there is any progress or not. To do the analysis, two to three DHSs of 19 countries were analysed, this allowed examination of the trend from 1990 to 2003. Three measures were used and these were readiness, willingness and ability which are all covered in the DHS. These measures were applied to fecund, currently married and cohabiting women. The results showed that in many African countries knowledge of pills and injectables has increased, more people don’t want to have more children and couple are discussing about family planning more than previously.

Paper 3: Infertility: The Hidden Tragedy within family planning “OR” Tossing the Family Planning Coin, infertility Exposed: Perhaps an Evenly Weighted Coin will Prove the Best Practice?
Presenter: Sheryl Vanderpoel, World Health Organization
Presentation summary
The presenter explained that in most family planning sessions the issue of infertility is not mentioned but it is one of the sexual and reproductive health problem that need a lot of attention because social stigma which it carries with in the community. She explained that most infertile couple are stigmatizes in the community and sideline in most of the activities because they have no child. She explained that the most affected are the women even though 20% of the cases are men. The presenter explained that although the number of infertile couple is big there are no services available for them in the health facilities and asked for the need not to regard infertility as part of natural contraceptive but to view it as a sexual and reproductive health problem. She also explained that in giving contraceptives to women we have to give an assurance to the women of assistance in case of secondary infertility, which affects about 168 million people worldwide. In her analysis most women who infertile they end up being prostitutes, or have multiple partners and they end up being reservoirs of STI's and HIV in the communities.
Paper 4: Population and Health in National Adaptations Programmes of Action (NAPAs) for Climate Change

Presenter: Clive Mutunga, Population Action International, United States of America

Presentation summary

The presenter explained the link between climate change and population in that if the population grows rapidly then the pressure on the land will lead to environment degradation which have a bad effect on the lives of people since there will only be small resources to be shared by a large group of people. Because of this there is need for governments to have policies that can improve management of climate related risks devising mechanisms to ease the pressure of the resources. National Adaptation Programmes of Action (NAPAs) help governments to identify priority activities that respond to their urgent and immediate needs with regards to adaptations. The presenter explained that there is need to align NAPAs with National Development Planning Process, including poverty reduction strategy papers although this has been a challenge so far in the countries where the implementation is being done.

Discussion

The moderator explained that there is a need to learn more on the stalling of population in Kenya and learn some from this and also adapt some best practices observed from the Kenya situation. Also there is need to look critically on the relationship of CPR and population stagnation so that we can have a better understanding of fertility trends in Sub-Sahara Africa. On infertility the session participants agreed that infertility is being neglected in most of the countries and there is need to put more effort in understanding the impact of infertility on the couple and also the community. The presenter emphasized the need for more studies to look at the relationships of infertility and behaviors that put women in risky trades activities e.g. prostitution.

Key Recommendations

Need to look critically on relationship of secondary infertility and family planning use and assurance of treatment of secondary infertility to those women seeking family planning. More studies needed to look at relationship of Contraceptive Prevalence Rate (CPR) and Fertility. Need to look at the role of culture and infertility and also the effects of infertility on mental health of the couple. There is need for political will of Governments and involvement of civil society for the success of NAPAs in the LDC s and small island states.

SESSION B05: COMMODITY SECURITY II

Moderator(s): Moses Muwonge, UNFPA, Uganda; Sarah Clark, Futures Group, USA

Presentations

Presentation 1: Contraceptive Security: Incomplete without Long-acting and Permanent Methods of Contraception

Presenter: Roy Jacobstein of Engender Health, United States of America

Presentation summary

Contraceptive security (CS) is incomplete if LAPM methods (Long acting/Permanent methods) not available. The LAPM all need essential medical and surgical instruments, and clinical staff. The presenter said it's worth considering language used in CS as it conditions the mind. The presenter said that when one has short acting contraception, it does not guarantee that you have a program. The presenter said food for thought was; Is vasectomy a contraceptive? Female Sterility is not a product, but is it a contraceptive? The presenter said that some of the LAPM need unique equipment without which you cannot provide methods and services. Failure rates are higher with shorter term methods because one needs frequent, regular use, and humans are imperfect. Withdrawal and condoms were not far apart in effectiveness according to his survey. According to data, the implant is 50 times more effective than the
in injectable and that 1/10 pill users will get pregnant. There is high demand, unmet need, and low IUD and implant use. One out of every five couples generally have desire to limit births. At least all women should use LAPM, but at least they should have a choice (reproductive intention and contraception choice). In the UK, USA, and Canada, LAPM is about 35% in use. By removing barriers to who can provide methods and making them available, it is possible for more women to access more methods.

**Presentation 2:** The Procurement, Planning, and Monitoring Report: Towards Donor Coordination in Contraceptive Security  
**Presenter:** Linda Cahaelen from USAID, United States of America

**Presentation summary**  
Procurement Planning and Monitoring Report (PPMR) is a tool used by donors to ensure countries have what they need, provide Emergency Contraceptives to countries with looming or current need. The presenter mentioned that previously, donors relied on anecdotal data before giving countries FP, but now using this tool they can check how old data is. PPMR shows stock levels in 16 countries, enables donor groups to see where stocks are low and where the need is, and if the donors are able to respond, how quickly the product is used in the country and when the next stock is coming in. Benefits of PPMR has been helping in averting stock-outs and oversupplies to curtail expiration of FP. PPMR has facilitated two transfers of IUDs between countries (between Mozambique and Rwanda) and thus showing donor groups what was going on. PPMR provides a regular pathway for donor groups to talk to each other and also to talk to country officers. Limitations: donors cannot always respond to every single need. It is difficult to get data from countries where USAID projects have no supply chain mandate and yet if PPMR were there, data collection would be made easy and takes 1 hour-half day to collect information. The data collection schedule for PPMR is flexible i.e. monthly, quarterly, etc.

**Presentation 3:** Health Sector Reforms and their Effects on Contraceptive Security: The Case of Malawi  
**Presenter:** Jayne Waweru, USAID/Deliver Project

**Presentation summary**  
In the last 2 years there was a noticeable increase in stock-out reports, especially DMPA in facilities whereas there were supplies at regional and central warehouses. The aim of the presentation was to show how policy reforms have affected Contraceptive Security (CS) in Malawi and the unintended consequences of the health sector reforms on CS. She gave an example that one time when trucks needed to bring fertilizer, they left the contraceptives and first brought fertilizer, which affected the supply chain. The Maternal Mortality Ratio has continued to decline in Malawi since 2000. 64% of all contraceptive use in Malawi is DMPA. They require a logistic system that can use data to quantify need, minimize wastage in warehouses, and re-supply quality product. All this should be supported by supportive policies. Reforms like SWAp, integration and decentralization, prioritization of curative and preventative services so contraception is rationalized, and issues like should donors fund FP the same way they fund other health supplies such as anti-malarials. Lessons learned: there should be indicators to routinely look at supply, procurement officers hired and trained, and health workers must be trained on how to procure these FP products.

**Presentation 4:** The Strategic Pathway to Reproductive Health Commodity Security: Five Years and 50 Countries Later—What Have We Learned?  
**Presenter:** Leslie Patykewich, USAID/Deliver Project

**Presentation summary**  
The aim of study was to look at the progress made by the SPARHCS framework/tool/process which has 7 components. This reminds us that we do not work in a vacuum and the client is the central beneficiary. The presenter said that the framework helps to clarify the process and the tool helps in diagnostics and assessment like key informant interviews and secondary data analysis. As a process, findings are taken from the process and used as a foundation for the development of new projects. The presenter mentioned that the tool has been used in many countries and has encouraged the uptake of FP. SPARHCS has helped keep the focus on FP in an integrated world, showing groups the importance of collaboration and ensuring no duplication. It has helped countries gain a longer term approach to funding using government finances e.g World Bank credits, internally generated revenue. 26 countries have reported having specific CS strategies which showed commitment. SPARHCS succeeded because it is
multisectoral and every branch has a role to play which helps move it forward. It is holistic and uses a system approach, it is client-centered, adapted to specific countries, and is designed for short and long-term solutions. Challenges /lessons learned: some strengths are challenges e.g. due to the holistic approach, one cannot delve deep into issues. Because long-term people tend to lose steam along the way, it keeps the focus on FP, yet there may be other issues to prioritize. Lessons learned: commitment is key, except in Tanzania where the client was engaged. Lack of engagement of key issues that need to be highlighted and the issue of equipment and supplies for LAPM are challenges. Uptake has been remarkable, but there is a lot more to be done to ensure we are responsive to the country needs. Unmet need for FP is still high, therefore need to work more.

**Presentation 5:** Contraceptive Security Index 2003-2009: Monitoring Progress toward Achieving Contraceptive Security
**Presenter:** Joan Robertson, USAID/Deliver Project

**Presentation summary**

Contraceptive Security Index (CSI) uses 17 indicators grouped into 5 components to monitor CS i.e. supply chain logistics, financing, health and environment, people’s ability to access FP and utilization. Each of 5 components is worth 20 points. The presenter noted that the biggest improvements in supply chain have come from Africa. Financing looks at government health expenditures and this has increased overall globally. In terms of people’s ability to access FP, the greatest improvement has been in Sub-Saharan Africa. In terms of utilization (method mix, unmet need, CPR, TFR, etc), Latin America has shown progress.

**Discussion**

The session chair gave his food for thought on commodity security; he wondered whether running a vertical program is more sustainable than an integrated program. He felt that the private sector plays a big role in issues. The chair shared that when one goes to a hospital needing contraceptives, it is not an emergency compared to malaria. This means the clinic waiting time for FP is long. On service characteristics; are staff able to use the IUDS? The other issue is disposing of the products when they expire. Does government have a budget for clearing costs on commodities since this impacts access? Should we integrate commodity supply/FP with emergency medicine?

In response to a participant whose responsibility it is to provide supplies for the LAPM, especially the services after supplying the methods, the presenter noted that USAID does not provide supplies. Other than USAID and UNFPA are there other donors who provide funds for Contraception? The presenter said the World Bank and RH Interchange provide information on what each donor does.

A participant wanted more information on the unintended consequences of SWAP on CS. The presenter responded that systems that support SWAP were not able to support integrated management i.e. increase from 22 products to 1500 products without increase in Human Resource. She recommended that vertical programs doing well should be allowed to remain until funding and human resource is updated before integration.

USAID Kenya wondered why DELIVER was pushing for LAMP yet Kenya’s CPR is now 46% (after recent DHS) and they are mainly using injectables. She added that in Africa the nurses provides all services and it will take time for her to do a long-acting method. When we push for LAMP are we cognitive that for Africa, meeting this need is virtually impossible? The presenter responded that the push for LAPMs is because they are under-utilized and in fact Kenya and Malawi had shown more popularity of LAPMs according to his data. He noted that Depo has huge discontinuation rates due to complexities, so even though LAPM have more systems/service requirements, it is worth pushing.

Marie Stopes Tanzania said they have a need for conception data and wondered whether DELIVER could support them to come up with a system to get conception data and not imports and warehouse data.
UNFPA Vietnam said that in Asia there is clear commitment from government but in Africa seems to be donors USAID mainly. He added that commitment from government needs to increase for sustainability and government needs to take on capacity issues e.g. procurement that were previously done by donors.

The National Family Planning Services in Zimbabwe wondered what criteria is used for a country to become a member of PPMR since Zimbabwe is not included. She was asked to get in touch with USAID colleague to assist in joining PPMR. Responding to the question of the challenge of how to measure the use of FP after it has reached community and what plans they have to sustain CS in Malawi, the presenter said they are using various leaders in the countries to continue advocating for FP. They are focusing on the role of FP in reduction of MMR to stimulate interest in FP and enhance contraceptive commodity security.

USAID does not subscribe to basket funding, a participant from Rwanda was told. However, bulk contraceptives in Malawi are procured using USAID money, but the government funds other components of SWAp. USAID can help out when there is problem with basket funding. He said Rwanda has funding from The Global Fund for contraceptive procurement outside of USAID.

Responding to questions of why the female condom did not appear on list of methods, USAID does procure female condoms. Session chair Mr. Muwonge ended by asking: When determining countries need does one use unmet need or logistics/service data?

SESSION C05: INTEGRATING FP AND MATERNAL AND CHILD HEALTH II

Moderator(s): Liliane Christine Luwaga, Ministry of Health, Uganda; Oladosu Ojengbede, University of Ibadan, Nigeria

Presentations

Presenter: Paul D. Blumenthal, Stanford Program for International Reproductive Education and Services (SPIRES)
Presentation Summary
The presenter stated that there were few successful programmatic experiences with interventions of inserting PPIUDs (post-placental), a period which was highly opportune. The project was intended to improve access to long term effective contraceptives. Through a 9-day competency based training of PPIUD insertions, 38 devices were inserted in Zambia with slightly more (45) devices in Nigeria in the presence of a trainer supervisor. The timing of insertion which occurs immediately after the placenta was deemed right as the cervix is fully open, few accessories required, besides the provider and client are available. The presenter mentioned that PPIUDs were only inserted in sensitized women who had consented during ANC visits or early labor. Averagely a trained nurse/midwife needed 4 insertions to achieve competency. The presenter revealed that for sustainability purposes, the PPIUD services ought to be integrated with ANC and post partum care. In an African setting, the competency-based training in PPIUD insertions is feasible and would increase on the number of clients. In addition, training using models reduces on the number of insertions required for competency.

Paper 2: Expanding Access to Contraceptives and Improving Couple Communication about Family Planning in South-West Nigeria: Lessons Learned
Presenter: John Chukwudi Bako, Society of Family Health, Nigeria
Presentation Summary
Using commercial sector distribution system Society for Family Health Project through the PSRHH project distributed family planning commodities to commercial sex workers, soldiers and their spouses in Ogun state. The question raised during the study was that “if people can not discuss issues of sexual health how then could they talk about family planning?” As a pointer to success, the presenter revealed that
women were taught how to initiate condom, sex and family planning talks with their spouses. Interesting findings were observed among the women who were found not interested in having more children, condom use and accessibility was increased among the target population. The presenter pointed out though many women knew the different contraceptive methods they did not know how to communicate with their spouses which calls for intervention.

**Paper 3: Quality of Family Planning Services in Ethiopia**  
**Presenter:** Abiy Seifu Estifanos, School of Public Health, Addis Ababa University, Ethiopia  
**Presentation Summary**  
Although governments endeavor to provide health services to all its nationals, the question of quality reproductive health services is often neglected. The study was based on client exist interviews on 1,170 female respondents accessing family planning services at the health facilities in Orombia region in Ethiopia. Reasons given by the respondents for attending that particular health facility included the physical accessibility, availability of health workers, affordability of the services offered and the less waiting time. Findings shows more than half of all the respondents were not asked by the providers how many children they wanted to have, they did not discuss FP or even showed them IEC materials. Though the providers decided the FP method to be used by the client, they did not discuss the side effects of the family planning methods given. The presenter said that most of the clients were satisfied by the services offered by the providers. He recommended the need to link up STIs/HIV/AIDS with family planning services offered.

**Paper 4: Assessing the Need of a Family Planning Component in the Safe Motherhood Project in Western Uganda**  
**Presenter:** Richard Semujju, Marie Stopes Uganda  
**Presentation Summary**  
According to the presenter, it was realized that there was a missed opportunity where by many women were having too many children and too close. The study carried out by Mariestopes Uganda, set out to identify the gap, explain the low uptake of family planning services in the study area. They also wanted to establish the demand among clients and the willingness of health workers to provide FP services. The survey which was conducted among clients who had vouchers for ANC and for safe delivery in the various distribution points, presented a strong need for family planning among the clients. The presenter further said that there were barriers among faith based organizations that were not promoting FP, and that most providers were only giving out traditional FP methods. In conclusion the presenter said that the safe motherhood project was a success, they recognized low post partum attendance and the great unmet need for Family planning services among rural women whose TFR was 6 and above.

**Paper 5: Piloting and Sustaining Post Partum IUD services in Zambia**  
**Presenter:** Josselyn Neukom, Population Services International  
**Presentation Summary**  
With an aim of assessing the feasibility of Post partum IUD to increase IUD use in Zambia, the project established partnerships with clinics offering ANC services and with administrators. They further created demand among clients and provided competency based training to selected enthusiastic nurse midwives. For the 9 months period (February-October) a total of 655 PPIUD clients were served by the ten selected health facilities. The success of the project was attributed to the continued demand created among the clients attending ANC, IEC materials and the PPIUD trained providers who also did the sensitization. In addition committed, competent PPIUD providers and the positive labor ward teams helped in the creation of demand and provision of the services to the clients. The presenter recommended strategies of increasing the uptake of PPIUDs though advocacy with government officials, facility administrators/managers. Support supervision, dedicated PPIUD providers and targeted demand creation at various ANC clinics would scale up the uptake of these services.

**Discussion**

According to one of the participants, paper 2 on expanding contraceptives to clients in Nigeria did not come out clearly, whether the clients were served or not. As regards the quality of health services one
participant mentioned that it was good that research focuses on clients' perception of the services other than being defined by the health workers. Concerns were raised to presenters about PPIUDs, as participants said that it was obvious that pregnant women, those in labor or those who had had a birth would definitely not want to have a child. The question was whether they really needed the services or they were easily exploited because of their status. One participant wanted to know if there were infections recorded during the project and whether they had compared their findings with the standard procedures of inserting IUDs.

Paper 1 presenter said that the insertions were done about 10 minutes after the placenta was out, it was done all the way to the fundus usually manually since 4 hours after delivering would be difficult and required the use of gargets. He mentioned further that plans were under way with a Tanzanian factory which was working on something to help with the insertion without using forceps or manually. Beyond 48 hours after delivery no PPIUDs were done on women, they only do the insertions when women come back after 6 weeks, besides many women would like to leave the hospital with their FP method inserted.

The presenter of Paper 3 was asked why the quality of FP was assessed in the perspective of women and leaving out men, whether the characteristics of quality FP services were read out to clients or they were left to answer on their own. In response he said it was a pre-coded questionnaire and that men were not involved as they did not attend FP clinics, he however said that they would explore men’s perception in future.

**Key Recommendations**

Replication of competency based PPIUD trainings could make post-placental IUD insertion more prevalent and popular. Dedicated and enthusiastic service providers can help in scaling up on FP services in the hard to reach areas. There is a need to link family planning services with STI, HIV/AIDS services offered at the different health facilities. For clients to access easily contraceptive, it important that the service providers discuss with clients different methods, side effects and help clients decide on an FP method of use.

**SESSION D05: CANCELLED**

**SESSION E05: NOT RECORDED**

**SESSION F05: CONTRACEPTIVE PRACTICE IN ASIA**

*Moderator(s)*: Kuhu Maitra, Abt Associates, USA; Michelle Hindin, Johns Hopkins Bloomberg School of Public Health, USA

**Presentations**

**Presentation 1**: Contraceptive Use is More Equitable than Maternal-Child Care in India: Exploratory Analysis  
*Presenter*: Ram Faujdar, International Institute for Population Sciences

*Presentation Summary*

More research has led to additional reasons that support family planning. The presentation is based on the four pillars of maternal health: antenatal care, obstetric care, institutional delivery, and family planning, with the main purpose to advocate for the integration of family planning and maternal health. The presenter used data from the DLHS, which provides information on 90,000 women in India. While the Maternal Mortality Rate (MMR) and Contraceptive Prevalence Rate (CPR) have improved in the past 30 years, institutional delivery has remained relatively unimproved. Results from the data analysis reveal that CPR and institutional delivery are strongly correlated with education level and wealth. However, with a
government compensation program, 72% of mothers from the poorest population sector currently receive compensation for transportation and medical costs relating to institutional child delivery. The presenter recommends that while contraception use is generally equitable in India, equitable maternal health needs to emerge as well.

**Presentation 2: Contraceptive Use and Method Choice in Urban Slum of Bangladesh**  
**Presenter:** S.M. Mostafa Kamal, Islamic University  
**Presentation Summary**  
Bangladesh is often considered a success story in family planning, with an impressive increase in Contraceptive Prevalence Rate (CPR) and a decrease in Total Fertility Rate (TFR). Although Bangladesh has a small population, it has a high population density, especially in the urban slums. The TFR in urban slums is higher than for other urban populations. The study used the 2006 Bangladesh Urban Health Survey, and used bi-variate analysis to study the socioeconomic and cultural factors that impact contraception use and preference. Analysis results show that slum dwellers receive the majority of contraception from the private sector, and are willing to pay for contraception. Among slum dwellers, there is a moderate level of modern contraceptive method use. The presenter commented that family planning in Bangladesh urban slums are mostly female-based, and he recommended a renewed focus on male condom use.

**Presentation 3: Evidence Based Decision Making for Increasing Current Use of Oral Contraceptive Pills and Condoms in Rural Areas of Jharkhand, India**  
**Presenter:** Amajit Mukherjee, PSI India  
**Presentation Summary**  
The Jharkhand region has a high Total Fertility Rate (TFR) in comparison to the rest of India. The presenter discussed the initiated two-year campaign, which targeted married people who were not sterilized. The campaign had two aspects: supply and demand. For the demand aspect, the program used multiple channels, such as media and peer activities (wall paintings, group meetings, street teams, poster on shops that stock family planning methods) to increase the demand for contraception. For the supply aspect, the program provided contraceptive methods to shops to sell to the public and counselors to advise those who seek contraception. The results of the campaign showed that with increased exposure to the campaign, family planning use was higher. Certain factors required increased exposure in order to develop, including spousal support, which required at least six exposures to develop. Lower exposures to the campaign were required to improve determinants, while higher exposures were required for behavior change.

**Presentation 4: Innovations for Expanding Contraceptive Use in Rural Afghanistan**  
**Presenter:** Douglass Huber, IDEAS Inc.  
**Presentation Summary**  
In Afghanistan, contraception is 300 times safer than pregnancy. The presentation discussed a pilot project in three regions of Afghanistan that looked intently at three topics to increase CPR: community health workers, health posts, and households in the health post catchment area. The project involved community and religious leaders heavily, and aimed to improve family planning services in order to increase CPR. Changing the family planning atmosphere was crucial in increasing contraceptive uptake, and the fact that birth spacing is consistent with the Quran provided religious support for contraception. The project improved the services offered by community health workers by creating simple job aides. The project yielded unexpected tremendous change in contraceptive prevalence, with a 5% per year increase in CPR. There was no previous DHS data on CPR, so the project included a comprehensive study to confirm the results. Different regions exhibited different contraceptive preference, with injectables making substantial improvements in all three regions. The project was concerned that other health services would be neglected with the increased attention on family planning, yet treatment for other health issues, such as diarrhea and malaria actually increased during the project’s duration. The project found that working closely with the community and emphasizing MCH can yield incredible improvements.

**Discussion**
For the first presentation, questions were raised regarding the potential challenge of keeping the stores stocked with contraceptives, and why the eligibility requirements for females were up to 29 years old when there is such a pervasive trend of early marriage. The presenter responded that the project was largely based on social marketing, so stocking the shops is an entrepreneurial opportunity for the shop owners. The presenter comments that while there may be dropouts of stores, the cycle generally works. In terms of the late cutoff for the age of female participants, the presenter explained that the beginning eligibility, age 15, was set due to the early marriage trends, and the late age limit, 29, was set because according to the National Health Survey of India, fertility continues until age 29. Also, women prefer to get sterilized after age 30.

For the second presentation, the audience had questions about male involvement in contraceptive decision-making, and if there was an effect of having a son child on use of contraception. The presenter responded that men are in the sole position of decision-making, although women in slums generally had higher autonomy. The presenter commented that involving men more in the decision-making process could hopefully increase CPR. The presenter also commented that women who had at least one son had a higher CPR than women who had no sons, showing the general preference for sons.

The final presentation received a substantial number of questions. The audience inquired about the variation in contraceptive method preference throughout the three regions, how injectables were distributed to clients, and what the international community is doing to scale-up the program that showed such positive outcomes. The presenter explained that the preference for condoms in one region is vastly different than others. This is because during the Taliban’s rule, a large population fled to Iran, where there is a high rate of condom use. The bottom line is that there is a wide range of contraceptive preference in regions of every country, and we must accommodate for these different preferences. The audience also asked about the process of women receiving follow-up injectables. The presenter responded that community health workers were trained to administer injectables and allow them to administer the first injection, which previously had to be administered by a physician. The project found that community health workers had myths and fears about injectables, and creating job aides helped them feel more confident talking about and administering injectables to women who sought them.

**Key Recommendations**

Working closely with the community can have tremendous impacts on project outcomes. Male involvement in contraceptive decision-making is crucial in increasing CPR.

**SESSION A06: MEN AND FAMILY PLANNING II**

**Sponsor:** Family Health International

**Presentations**

**Paper 1: Factors That Influence Male Involvement in Sexual and Reproductive Health in Western Kenya: A Qualitative Study**  
**Presenter:** Monica Onyango, Boston University School of Public Health, United States of America

**Summary of Presentation**  
The presenter described the findings from a qualitative study conducted by Kisumu Medical and Education Trust (K-MET) in three provinces in western Kenya. K-MET sought to determine factors that influence male involvement in sexual and reproductive health (SRH) and the best strategies for improving male involvement. In-depth interviews and focus group discussions were carried out at five private health facilities. The researchers found that the two main factors influencing male involvement in SRH are gender norms and traditional approaches for implementing programs. Specifically, gender norms that negatively influence men’s involvement include cultural practices, parenting practices, lack of male involvement in fertility decisions, stigmatization of sexually transmitted infections, and the low levels in which men accompany their wives to the health clinic. Traditional approaches to implementing SRH
programs that inhibit men’s involvement include a focus on maternal and child health and lack of focus on educating men. Based on the results of this study, the presenter recommended that strategies to improving male involvement should include involving community leaders, creating male-friendly clinics, and holding seminars and workshops to create awareness among men.


**Presenter:** Constance Ambassa-Shisanya, Family Health International, United States of America

**Summary of Presentation**

This study examined whether or not men influence the discontinuation of DMPA (Depo-Provera) among women in Nyando District, Kenya and if so, how they influenced discontinuation. The presenter explained that research on contraceptive discontinuation often ignores men and their potential influence. Through focus group discussions with male leaders and husbands of DMPA users it was found by the researchers that the factors influencing discontinuation of DMPA could be categorized into the following three themes: logistical, medical and social. Logistically, respondents described stock-outs and a lack of money to pay for DMPA as reasons for discontinuation. Medical reasons such as the fear of side effects as well as misperceptions about DMPA were also listed as reasons for discontinuation. Finally, a variety of social reasons for discontinuation were described by men including fertility desires, sex preference of children, tradition of naming children after deceased relatives, and a belief that DMPA leads to prostitution. The presenter concluded that men do have a strong influence over women’s decision to use contraception, however, men also lack adequate knowledge about DMPA. In order to overcome some of these obstacles, the presenter recommended fully engaging men by explaining the benefits of contraception, dispelling myths, and describing side effects and ways to support women when they experience side effects.

**Paper 3: Using Male Educators to Increase Family Planning Uptake Among Young Couples: The Malawi Male Motivator Project**

**Presenter:** Dominique Shattuck, Family Health International, United States of America

**Summary of Presentation**

This study examined the impact male motivators have on contraceptive uptake in Mangochi Province, Malawi. For the project, 40 men were recruited and trained as male motivators. Nearly 400 men participated in the study of which 197 were randomized to the intervention and 200 served as controls. Men who were in cross-generational relationships were targeted for the project. Men who were in the intervention group received five visits from male motivators over 6 months. Surprisingly, men in both the intervention and the control groups showed a large increase overtime in contraceptive use, however, the increase was greater among men in the intervention group. The presenter offered the Diffusion of Innovation Theory and Question-Behavior Effect as two possible explanations for the increase in contraceptive use for both groups of men. Men in the intervention group showed a greater frequency of discussing family planning with their spouse than men in the control group. Communication regarding family planning was statistically significantly associated with a greater uptake of contraception. The presenter concluded that the male motivator project is an effective intervention for increasing contraceptive use. More research that examines the link between communication and family planning uptake is needed.

**Paper 4: Myths and Misinformation, Factual Information, Discussion About Family Planning and Contraceptive Use in Nigeria**

**Presenter:** Muyiwa Oladosun, MiraMonitor Consulting, Ltd., Abuja Nigeria

**Summary of Presentation**

The results from a study that utilized data from three rounds of the National HIV/AIDS Reproductive Health Survey (NARHS) resulting in over 31,000 male and female respondents were presented. The surveys were collected in 2003, 2005, and 2007. From the analyses, the presenter found that geopolitical zones, education level, religion and socio-economic status influenced contraceptive use for both men and women. Greater number of partners was also positively associated with contraceptive use for both men and women. Residence and age had an indirect effect on women’s contraceptive use while marital status had an indirect effect on men’s use. Discussing family planning with one’s spouse, other people, and
health providers was associated with men and women’s report of contraceptive use. Results showed that men believe in myths more often than women. According to the presenter, innovative programs that change misperceptions about contraception should be implemented. Programs should be designed to target specific groups of people.

**Paper 5: Male Partner’s Roles in Women’s Use of Emergency Contraception**

**Presenter: Kelly L’Engle**, Family Health International, United States of America

**Summary of Presentation**

The presenter described the results of a study conducted in Ghana with male influencers of women’s use of emergency contraceptive pills (ECPs). Men were considered influencers if they buy ECPs, provide support in instrumental ways, and/or encourage a partner to use ECPs. The researchers used a mixed-method approach involving a survey and in-depth interviews to examine men’s role in women’s use of ECPs. Reasons men gave for buying ECPs ranged from not using other methods of contraception, having sex during a woman’s fertile days, missed pill or injection and condom slipped. More than 80% of men correctly reported that ECPs can be used for up to 72 hours after intercourse and that ECPs do not cause an abortion. A quarter of men believed that it is okay for a woman to repeatedly use ECPs. The presenter suggested that some men appear to play a supportive role in women’s use of ECPs while other men play a more coercive role. It was recommended by the presenter that ECP be promoted, however, with a greater understanding of gender dynamics. Additionally, joint decision-making and men as equal partners in family planning should be encouraged.

**Discussion**

One woman in the audience raised several questions to the third presenter about the diversity of the people in Mangochi Province as well as the large number of other programs that are present in the province. The presenter explained that ethnic data would be explored further but was not included in this analysis. He also explained that their study tested the difference between a treatment and a control group, which helped to control for the impact of other activities in the area. Another audience member asked what the nature of the sexual relationships were between the male influencers of ECP and their female partners. The fifth presenter explained that many of the male influencers cohabitate with their partners, however, more in-depth information is needed.

The first presenter provided further recommendations for including men in SRH by stating that in the beginning men need to be counseled by other men. After the men have been counseled alone, the women should be brought in for couple counseling. An additional question on whether or not there should be an emphasis on men’s SRH needs drew differing responses from the presenters. The third presenter emphasized the importance of the dyad in SRH and that there needs to be a focus on the couple rather than just one sex. The first presenter believed that male-friendly SRH clinics should be considered to improve men’s appreciation for the services.

**Key Recommendations**

- Based on findings from Kenya, it was recommended that the gender norms in the western provinces as well as the traditional approaches to providing SRH be addressed in order to improve men’s involvement in SRH.
- Men in Kenya were also found to lack correct contraceptive knowledge, which seemed to influence women’s discontinuation of contraception. Men should be fully engaged in family planning by increasing their knowledge as well as their ability to be a source of support to their wives when they are experiencing side effects.
- Communication on family planning between men and women was found to be associated with family planning uptake in the third presentation on male motivators. More research is needed to further explore this association.
- Participants exposed to male motivators were more likely to report family planning uptake than participants not exposed to the male motivators. It appears that male motivators is an effective
intervention for increasing family planning uptake and should be replicated and evaluated in other sites.

- Different factors were found to influence men and women’s decision to use contraception in Nigeria, thus interventions need to be designed to target specific groups of individuals.
- Support for partners’ use of ECP was found to range from highly supportive to coercive thus the need for a greater understanding of gender dynamics in the context of ECP use is necessary.

SESSION B06: CONTRACEPTION AND ABORTION

*Moderator(s):* Louise Lee-Jones, Marie Stopes International, UK; Charles Kiggundu

**Presentations**

**Paper 1: Patterns of contraceptive use and repeat abortion in Addis Ababa, Ethiopia**

*Presenter: Nkola Prata, Bixby Center for Population, Health, and Sustainability*

**Summary of Presentation**

The study presented was part of a larger prospective study and examined the family planning use patterns of clients demanding repeat abortions. Data was extracted from records, and there was no direct contact with patients (although there was direct contact with providers). The study examined the socio-demographic characteristics of women who had had repeat abortions, characterized their access to family planning services to limit or space childbearing, and made recommendations to help women meet their desired fertility.

Numbers of pregnancies were greater for women who had had a previous abortion. Those having a repeat abortion were more likely to be using a short-term method compared to women having their first abortion. Odds of repeat abortion increased significantly with the number of pregnancies. Odds of repeat abortion were also lower for single women, so were thus associated with married women. Secondary education and working women were also more likely to have a repeat abortion.

Women had been categorized women into type of contraceptive user: nonusers, short-term users (pills, condoms, and emergency contraceptive), and long-acting users. When women were stratified in this way, short-term method users and nonusers were most significantly affected by parity, age and another factor for the likelihood of a repeat abortion. For women using long-term methods (mostly Depo), only parity and age affect the likelihood of repeat abortions.

Women presenting themselves at clinics for abortions stated that discontinuation of a family planning method and misuse of a contraceptive method had caused their pregnancy. For those discontinuing a method, women stated that they had wanted to switch methods due to side effects, couldn’t find a method, and misunderstood how quickly fertility returns.

In summary, postabortion counseling needs to be improved in order to reduce contraceptive failure. In particular, if provided methods fail, what else can be provided so that the incidence of repeat abortion decreases?

**Paper 2: Factors associated with induced abortion among women aged 15-49 years in Hohoe district of Ghana**

*Presenter: Roderick Larsen-Reindorf*

**Summary of Presentation**

Abortion is legal in Ghana; however, there is lack of knowledge by providers on this law. Therefore, many women opt for unsafe abortion, which greatly contributes to maternal mortality. The Volta region, where Hohoe District is located, accounts for 18 percent of the national burden of abortions.
A survey was administered among 408 women aged 15-49 in the Hohoe district to identify factors associated with induced abortion. Among survey participants, one in five women had had an induced abortion. Among those aged 20-29 years, 80% had had an abortion.

The most cited reason for induced abortions was so that women would not disrupt their education or job. Other frequently cited reasons were that women felt that they were too young to have children and that they would not be able to take care of a new baby. To obtain the induced abortions, 2/3 of women had gone to a medical doctor or to partners/friends. Nearly a third had used herbs or concoctions, and 10% had used “orthodox medicine,” largely misoprostol.

**Paper 3: Motivations and obstacles to use of abortion and contraceptive services in Ukraine**  
**Presenter: Rachel Louise Criswells**, Fulbright Ukraine  
**Summary of Presentation**

In the Ukraine (a middle-income country), despite highly negative attitudes towards abortion, there is a high abortion rate, a low contraceptive rate (compared to the rest of Europe), and high use of traditional methods of contraception. In addition, most of the abortions performed in the country are on an older cohort of women (those older than 35 years of age), which is an atypical age distribution.

This study sought to understand why Ukrainian women continue to use abortion as a method of contraception (despite its negative view) and the factors that stand in the way of contraceptive use.

One major reason is that beliefs from the USSR toward birth control and healthcare still linger in the Ukraine. The Soviet system of healthcare was curative and prevention was rare. Preventative birth control was considered dangerous as perpetuated by the USSR, and abortions were the main method of contraception during that time. Thus, passive and reactive attitudes of the people lead them to pay for abortions as needed. Abortion is a one-time cost and officially free (although there are costs associated with gifts for doctors and for additional medication) whereas contraception is a regular cost. In rural areas, contraception is not usually available. Lack of provider-initiated counseling also contributes to high abortion rates; over half of women did not receive family planning counseling after an abortion. In addition, doctors prescribe a “period of rest” after birth, abortion, or when changing from one family planning method to another. There is a belief that committed married couples should not use contraception because it signifies infidelity, despite women’s desire to limit childbearing.

There are many implications from this study, especially in light of current events in the Ukraine. There is an ongoing church-sponsored anti-abortion campaign, and government sponsored pro-natal campaign. There is a need for a prophylactic attitude towards family planning (and healthcare in general).

**Paper 4: Contraception and Abortion in Zanzibar, Tanzania**  
**Presenter: Alison Holt Norris**, Johns Hopkins Bloomberg School of Public Health  
**Summary of Presentation**

Semi-structured group interviews were conducted with Zanzibari men and women to see how they talk about social norms surrounding abortion. In-depth interviews were held with opinion leaders to understand how contraception, unwanted pregnancy and abortion are viewed in the community; with providers to understand the circumstances of their clients, the type of services they give, and their views on contraception, unwanted pregnancy, and abortion; with women who had had abortions and with women receiving post-abortion care to hear their stories around pregnancy, how they had come have an abortion, and their characteristics.

Low contraceptive prevalence in Zanzibar can be explained partly by the Muslim religion and fatalistic nature about pregnancy and childbirth. Women believe that God is the one who decides when and how many children and if one interferes, then one is changing God’s will. Culture also plays a part in the low contraceptive as if one is not wealthy, then it is viewed that one’s wealth is in one’s children. Mothers-in-law in particular tell women that they should be having babies.

Fear of side effects and a variety of misconceptions also contribute to low contraceptive prevalence.
As abortions are illegal in Zanzibar, induced abortions consist of ingesting or inserting into the vagina, ashes, laundry detergent, or herbs. Abortion and post-abortion care has been heavily stigmatized; and this combined with the lack of data on abortion prevalence make it difficult to estimate the magnitude of the problem. However, policies and attitudes have been slowly changing. In the past, police could be called if a woman came in for post-abortion care, but not anymore. Misoprostol has also registered for incomplete abortion and post partum hemorrhaging.

The Ministry of Health (MOH) in Zanzibar has recognized the importance of family planning and is becoming more active about promoting family planning. Family planning was reemphasized in the past year, and religious leaders were sent to Tunisia to observe family planning programs in action. The MOH is also interested in measuring abortion prevalence and increasing CPR, and collaborating with policymakers and providers to reduce poor outcomes from unsafe abortion.

**Discussion**

During discussion, the presenter clarified that there was no population level association between poor mental health as a result of abortion. Also, in many developing countries, the risks for pregnancy are much higher than risks of safe, legal abortion, when available. However, it was pointed out that abortion could not, and should not, be promoted as a method of family planning. Abortions are risky in many countries and family planning should be promoted to the fullest extent. Post-abortion care (PAC) should then be provided in cases of emergencies with family planning available during PAC.

**Key Recommendations**

Not Available

**SESSION C06: FRANCHISING FAMILY PLANNING (FP) SERVICES**

**Sponsor:** Population Sciences International (PSI)

**Moderator(s):** Rehana Ahmed, Social Franchising, Kenya

**Presentations**

**Paper 1: Private Sector Franchising for Long Term Methods in Kenya**

**Presenter:** Mrs. Musembi Veronica, Population Services International, Kenya

**Summary of Presentation**

The Kenya Demographic Health Survey (KDHS) 2003 estimates use of long term methods (IUD and implants) at only 4%. The public sector role in Intra-uterine Device (IUD) and implants is estimated at only 29% and 61.5% respectively. This implies that the remainder is inserted through private or non-profit clinics (KDHS, 2003). In addition, preliminary results of the KDHS (2008/09) revealed that unmet need in Kenya remains high and has stagnated in the last 5 years. Kenya has a Contraceptive Prevalence Rate (CPR) of 46%, which from the presenter’s point of view is quite encouraging. However, she asserts that Kenya can still improve as a country. According to the presenter, PSI made a decision to satisfy the unmet need through the strategy of franchising the existing private sector providers. This strategy mainly targets women of low economic background. This study specifically focused on what Kenya is doing in franchising family planning services. The presenter explained that after PSI’s initial mapping of private and public sector clinics in seven regions in Kenya, 113 were selected to participate in the study based on a set of selection criteria. A memorandum of understanding was then signed between these clinics and PSI for them to become "Tunza clinics" under the Tunza Family Health Network. 113 private practitioners were trained and branding of the network clinics commenced. The Tunza clinics underwent training in skill building in IUDs and implants got technical and program support from PSI staff and subsidies to help clients pay for IUDs. The challenges facing the franchising program in Kenya include myths and misconceptions about especially about IUDs, inadequate supplies and infrastructure that hampers long term methods and the difficulty of encouraging providers to generate demands on their own. The
presenter states that although not all these challenges are addressed by PSI, there is need for PSI to see how to comprehensively do conduct social marketing as they embark on a franchise program. Private franchising was found by the researchers to be a major part of the strategy in Kenya because the private sector is fairly extensive and has reached into the peri-urban and peri-rural areas.

**Paper 2: Franchising of Private Providers in Pakistan**  
**Presenter:** Dr. Malik Maheen, Greenstar Social Marketing, Pakistan, Guarantee Limited  
**Summary of Presentation**  
The presenter briefed the audience about Greenstar Social Marketing, a Non-Governmental Organisation in Pakistan, founded in 1991 by PSI. She added that since open talk on FP is not common or allowed in Pakistan, Greenstar “went under the umbrella” of PSI. Greenstar helps to improve lives and health of low income Pakistani by service provision, increasing supply and demand for family planning (FP) and maternal and child health products and services. The activities of Greenstar were summarized into 3; Training and developing its extensive private sector health care provider franchise, distributing contraceptives and other health products through private sector companies and generating demand for health promoting products and services. The presenter highlighted major challenges the staff at Greenstar Social Marketing as lack of political will, contraceptive insecurity and inadequate logistics and resources as the organization moves out to rural areas.

Greenstar brands the private providers after training them in FP service provision. In this study, the Greenstar Management Information System (MIS), the system that monitors program inputs and outputs, was employed to generate data for the study. This data showed 72 million Couple Years of Protection provided by Greenstar in the previous year. In the commercial sector and franchised clinics, Greenstar distributed over 100,000 IUDs and over 800 female providers were trained in IUD insertion. Results from the intervention show that Greenstar has the ability to successfully train and incorporate many of the private sector providers into its network. Greenstar FP products and services protect 1 out of every 4 married couples who use modern methods. Greenstar services reach 70% of clients coming from low-income areas through the private sector. The presenter argued that this system is sustainable through cost recovery and cross subsidization. The success of Greenstar in reaching people in need helps to achieve the goals of the National Population Programme in Pakistan.

**Paper 3: Expanding access to family planning products and services: the use of a second tier franchised network in Myanmar**  
**Presenter:** Dr. May Sandi Aung, Population Services International (PSI), Myanmar  
**Summary of Presentation**  
This study addresses issues pertaining to increasing access of contraceptives to low income women leaving within 3 hours of the Sun Quality Health Clinic (SQH), the first franchise network of private doctors. PSI/Myanmar began a pilot of a second tier of franchised health workers called the Sun Primary Health (SPH). This new SPH franchise network was launched in June 2008 for priority diseases and priorities in the rural areas, with a total of 788 SPH workers covering 31 townships. According to the presenter, most Myanmar women seek products from the private sector and the poor ones end up using substandard methods that are risky. PSI/Myanmar is now using social franchising to reach the poor and provide reproductive health (RH) services and products. The Fractional Franchise was established in 2001 to provide quality affordable services. A total of 88 SPH workers in 4 townships have been trained, 427 women have been referred for RH counseling to an SQH clinic and 430 have received an IUD. Results from this study shows that underserved communities can be reached and provided with RH services using second tier franchised workers. Currently 927 RH providers are in the network and 127 have been trained in Intra-uterine Devices (IUDs). The presenter stated that the main strength of the SPH network is its linkage to SQH, as women among other services can be referred to SQH clinics for injectables, hence expanding choice. This new franchise network has the potential of being successful as it is reaching those in the rural areas, with a variety of subsidized products and services.

**Paper 4: Franchising to Increase Access and Use of Long Term Method (LTM)**  
**Presenter:** Ms. Eldridge Cynthia, Marie Stopes International (MSI), Kenya  
**Summary of Presentation**
In this study, Eldridge and Ahmed assess the use of a partial franchise model by BlueStar Ghana to increase access and improve the quality of family planning (FP) services. The presenter chose to highlight Ghana’s franchising because it is the basis of their case study program and lessons learned can contribute to a global understanding of what is happening in franchising. BlueStar franchising, which began in 2008, is one of the core delivery channels for sexual and reproductive health services within MSI and BlueStar Ghana. The presenter explained that there is an increasing change in social franchising and it has become a popular mode of service provision, due to increased funding. In addition, franchising includes innovative financing and integration with other national development programs. One of MSI’s goals in terms of franchising is to ensure equity of access and demonstrate that it is a cost effective method. BlueStar MSI Ghana has 100 franchisees in clinics, pharmacies and chemical shops. The chemical shops/sellers were included in the franchise because they are often the first stop for clients. Fractional franchising is common and MSI is adding FP and safe abortion services to the existing services. Technical and program support are given to the private providers to expand impact and reach low and underserved/rural populations. The presenter argued that there is need to bring all service providers to one standard to achieve the public health goals of Kenya. In addition, franchise programs should work synergistically with MSI Ghana clinics and outreach for optimal success.

Discussion

Regarding the global success of franchising, the fourth presenter pointed out that successful franchising programmes today have mostly been in Asia. That there is need to show the world that it can also be done in Africa.

A member of the audience from Uganda questioned whether ensuring quality as mentioned by the second presenter also involves interaction with the client and not only the service provider. Many of the members in the audience requested clarity on this as they deemed it an important area of concern especially in ensuring delivery of quality and necessary services to the clients. In response, the presenter explained that yes, the clients are involved in ensuring quality. She added that current research is being undertaken on impact of services in the community and how clients perceive the services provided. So clients are interviewed and their recommendations used to better the services provided.

The audience raised a number of issues regarding the sustainability of the products. For the second presentation, audience members raised a contentious issue regarding some of the lessons relating to cost recovery programs, especially with the subsidized products when the private sector products may be expensive. The presenter explained that at Greenstar Social Marketing they have subsidized their products, and are currently moving into a phase on how they can own product production to avoid relying on donors. The moderator reacted by saying that part of sustainability is that donors always do keep coming back. Similarly, the first presenter clarified that FP services in Kenya are provided free by the government and Population Services International only comes in to increase demand for these services. The fourth presenter explained that many of the private providers were sustainable before BlueStar got involved. BlueStar franchising helps increase these providers’ income and client base and also recommend price indices.

The moderator concluded by pointing out the cross cutting issues across the franchising models. Major challenges to franchising include program security, quality assurance, political will, and issues of reaching the rural poor. All these issues need to be addressed on an ongoing basis for franchising networks to be effective.

Key Recommendations

- There is a need for more resources and logistics to effectively and adequately cover the expansion of services to the rural population.
- Increase political will for family planning services, especially in countries that suppress open discussion of sexual and reproductive health issues.
• Create mechanisms to ensure contraceptive security- a key concern for most of the audience members.
• Integration of the franchising system and its alignment with the national standards should be strengthened. All organizations need to adhere to a single standard to reach a country’s public health goals.
• Franchising programs and Marie Stopes International Ghana clinics need to work together synergistically for optimal success. This also applies to all the other franchising FP services in all other countries worldwide.

SESSION A07: NATIONAL FP POLICY AND ADVOCACY 1

Moderator(s): Hannington Burunde; Population Secretariat, Uganda; Sahlu Haile, Packard Foundation, Ethiopia

Presentations

Presenter: Hon Fanta Mantchini Diarra, Mali Parliament.
Summary of Presentation
The parliamentarian explained that in 2002, Malian parliament adopted a law on reproductive and that this demonstrated parliament’s political will to promote family planning. However, what was being done at the implementation level was completely different from this. This prompted the parliamentarians to conduct a national tour to see for themselves what was happening on the ground in terms of the law they had just passed. On their tour, they observed significant differences between the content of the law and its implementation. For example, there were higher prices of contraceptives even though there were established prices. Family planning was not emphasized to clients when they visited the health facilities. FP services were not accessible to all the rural areas of Mali. After the visit, the parliamentarians lobbied to the government to improve reproductive health services and improve the accessibility of FP to people in rural areas.

Paper 2: Repositioning Family Planning in Rwanda: How a Taboo Topic Became Priority Number One, and a Success Story.
Presenter: Laura Hoemeke, IntraHealth International. Rwanda.
Summary of Presentation
The presenter explained how Rwanda attained a Contraceptive Prevalence Rate rise of 17% (10% to 27%) in a short period of three years (2005-2008). She explained that this was achieved through a multi-level effort with the head of state declaring family planning as the number one priority in the national agenda. She explained that the stakeholders in the implementation included district mayors, community members, service providers and family planning program managers. The implementation included free family planning counseling services, improvement of FP services delivery through pre-service training in-service training and on the job training, payment of health care providers for performance and other incentives. It also included advocacy with political leaders.

Summary of Presentation
The presenter shared the success story of family planning in Kenya with the audience. The DHS reported stalled fertility in Kenya. She explained that there were different approaches to the program and this included advocacy, demand creation, training, logistic management and monitoring and evaluation. In terms of advocacy, meetings were conducted with parliamentarians, known people in the community, policy makers and the budget and finance committee regarding their commitments to RH. Demand
creation was done through training of peer educators, IEC materials, and drama and radio programs. Stakeholders used consolidated training materials to improve training. Improvements in logistic management were made at the Ministry of Health through on job training. A national monitoring and evaluation team was assembled to monitor the progress of the project. All of these efforts resulted in increased uptake of family planning in the implementation districts.

**Paper 4: Three Family Planning Policy options in Low resource settings- the case of Niger.**

*Presenter: Malcom Potts, UC Berkeley, United states of America.*

**Summary of Presentation**
In his presentation, the presenter outlined the reasons that family planning is essential for the social and economic growth of Niger. He explained that according to the population projections of Niger, the population would reach 53 million by 2050. This population growth will have adverse consequences to the nation that is already struggling with limited resources. The presenter suggested that policy makers should consider family planning when they are making their decisions regarding national interest. He states that in Niger, women with higher education tend to have fewer children. However, the current problem is that resources for provision of education are being reduced, making education for women an expensive and difficult intervention. Instead, the presenter argues for the promotion of family planning.

**Discussion**

The chairman of the session summarised the session by highlighting the need for governmental political will and for the better implementation of family planning programs in different countries. He also discussed the need for a readily available supply of contraceptives to the communities after demand creation has been conducted. It is illogical to create demand for contraceptives and then have no supplies available for the people who now desire them.

The session participants also highlighted the need to standardize national family planning materials so that the message being disseminated is the same for everyone. For the effective uptake of family planning services there is also need to have multi-sectoral advocacy rather than targeting a small population.

**Key Recommendations**

- There is need for committed leadership to achieve explicit gain in family planning in all nations, like the case of Rwanda.
- Policy makers should trained adequately so that they should have a better understanding of what family planning is all about, to remove the misconceptions which they usually have.
- Women should be involved and their voices heard if we are to make any progress in family planning projects.
- There is need to share family planning information across countries.

**SESSION B07: CONTRACEPTION AND ABORTION II**

*Moderator(s):* Getachew Bekele, Marie Stopes International, UK; Faujdar Ram, International Institute for Population Sciences, India

**Presentations**

*Paper 1: Contraceptive counseling and use after second-trimester abortion in South Africa*

*Presenter: Naomi Lince, Ibis Reproductive Health, South Africa*
Summary of Presentation
South Africa is known to have very liberal and progressive abortion laws. Approximately 25-30% of abortions occur in the second trimester and doctors do these abortions in hospitals. Almost all methods of family planning can be administered immediately following second trimester abortion. Even sterilization can be done although it is typically not given to avoid emotional decision-making influencing permanent reproductive decisions.

For the purposes of this study, eligible women were eighteen years old or older and the gestational age of the fetus was between 13 and 20 weeks. Furthermore they had to speak either English or Xhosa. The sample size of women fitting these criteria was 304 women. The demographic characteristics of these women varied greatly.

When asked about family planning, 3 women indicated that they did not intend to start a method post-abortion. Most of the women who indicated that they wanted to use a method chose injectables. Oral contraceptive pills followed as the next popular method of avoiding pregnancy. In terms of family planning counseling, 80% of women were given counseling before their abortion and 47% received it post abortion. However, many women indicated that they received inadequate counseling.

In terms of recommendations, the presenter argued that counseling of women following second trimester abortion needed to be improved. This counseling should include information on long-term methods, which require less patient participation. Also, patients should be followed up to understand their uptake of family planning and levels of success with the methods chosen. Finally, she suggested that family planning options for women post abortion should be expanded using advocacy.

Paper 2: A comparison of induced abortion, spontaneous abortion and ectopic pregnancy gynecology patients in Ghana
Presenter: Hilary Megan Schwandt, Johns Hopkins Bloomberg School of Public Health, United States of America

Summary of Presentation
Ghana has a total fertility rate (TFR) of 4.0, which is low compared to other countries in sub-Saharan Africa. However, it also has a relatively low modern contraceptive prevalence rate (CPR). This CPR has even fallen from 19% in 2003 to 17% in 2008. The presenter attributed the discrepancy in these numbers to abortion. Abortion is legal in Ghana but many Ghanaians are not aware of this fact and safe abortions are not readily available. Furthermore, abortion is heavily stigmatized.

The aim of this study was to identify unique characteristics of induced abortion patients as compared to spontaneous abortion and ectopic pregnancy patients. Study participants were recruited from two teaching hospitals in Ghana. All women were at least 18 years old, fertile and wanted to wait at least 12 months until they became pregnant following this most recent spontaneous abortion, induced abortion or ectopic pregnancy. The sample was comprised of 20% induced abortion patients, 73% spontaneous abortion patients, and 7% ectopic pregnancy patients.

For the analysis, the dependent variable was how the most recent pregnancy ended. Independent variables included relationship characteristics, individual characteristics and socio-demographic variables. In terms of results, women who had experienced induced abortion were more likely to have decision-making power and were also more likely to not disclose their recent pregnancy status to their male partner. In fact, while 24% of induced abortion patients did not disclose their pregnancy to their male partner, only 5% of spontaneous abortion and 6% of ectopic pregnancy patients did the same. They were also younger, less likely to be Muslim, and more likely to be single or in a consensual union. Characteristics of spontaneous abortion and ectopic pregnancy patients did not differ.

The study is limited by the fact that included information from only teaching hospitals. It also relied on self reports and did not include women who remained pregnant and did not abort the pregnancy. However, the research also gives several important lessons. Induced abortion patients are independent and need support from professionals, as they may not have informed their male partners. Ghanaian family planning
and abortion advocates need to work to raise awareness of the legal status of abortion in Ghana. This can increase the availability of safe abortion and the use of the service. Family planning also needs to be promoted as a means of averting the need for induced abortion.

**Paper 3: Characteristics of women seeking abortion-related services in Addis Ababa, Ethiopia**

**Presenter:** Tesfanesh Belay, Venture Strategies for Health and Development, Addis Ababa Ethiopia

**Summary of Presentation**

Ethiopia has a relatively high total fertility rate (TFR) of 5.4 and a desired fertility rate of only 4.0. This indicates that the population may have a high demand for abortion services. Thus, the goal of this research project was to understand the characteristics of women seeking abortion in Ethiopia to inform policy-makers and make recommendations and to make recommendations to help women to achieve their desired fertility.

This study occurred between October 2008 and February 2009 and included 1200 women in both public and private facilities. In this sample of women, the mean age was 25, 57% were employed, 54% were single and 75% had at least secondary school education. Women who had experienced unsafe abortion, however, were less educated than those who had sought safe abortion.

In terms of contraceptive history, women who had safe abortions used mostly short-term method or no contraception at all. Women who had unsafe abortion used less short-term methods, more long-term methods and more non-use as compared to those who received safe abortions. Most of the safe abortions occurred within the first trimester while most of the unsafe and incomplete abortions occurred later in the pregnancy. In terms of post abortion contraception, safe abortion clients left the clinic with short and long-term methods. Unsafe abortion recipients received more long-term methods or no methods at all. Interestingly, many of the women left the clinic using the same contraceptive method that they were using when they had their unintended pregnancy. Interviewed providers expressed that repeat abortion services are common.

In terms of recommendations, the presenter argued that Ethiopia needs to expand access to family planning methods and safe abortion to reduce the impacts of unsafe abortion. Furthermore, Ethiopian clinics need to reach out to single, low-income young women to increase their knowledge about contraception.

**Paper 4: Improving Quality of Abortion Services in Vietnam**

**Presenter:** Phuong Nguyen, Pathfinder International, Vietnam

**Summary of Presentation**

In Vietnam, the modern contraceptive prevalence is 57%. Abortion has been legal since 1945 but services have only been available since the 1960’s. In 1996, 1,300,000 abortions were performed. Vietnamese women also experience high contraceptive failure. In the past year, 15.2% of pregnant women reported having used a modern method during the conception period.

A strategic assessment in 1997 found the following issues with abortion services in Vietnam:

1- Lack of counseling
2- Limited contraceptives
3- No pain control
4- No post abortion contraceptives administered
5- Only dilation and curettage services offered.

A series of reproductive health projects are being institutes to improve the quality of reproductive health care including abortion. As a part of this endeavor, youth friendly services were offered beginning in 2004. They also created a training network to scale up quality services to 8 provinces. The reproductive health projects have trained 2300 providers on manual vacuum aspiration and 116 providers on medical abortion.
There are several challenges to the reproductive health projects in Vietnam. First of all, ultrasound, an expensive and time-consuming procedure, is overly used for pregnancy confirmation. Highly effective long-term methods need to be promoted as part of the method mix. In Vietnam, condoms are a large proportion of the method mix. This may be due to biased counseling and client preference for them. Thirdly, Mifepristone, an abortifacient used for medical abortion, is extremely costly and inaccessible. Finally, there is very little supervision on the quality of care for reproductive health services.

**Paper 5: Addressing Morbidity and Mortality from Unsafe Abortion: Assessment of Safe Abortion and Contraceptive Service in Ethiopia**

**Presenter:** Tibebu Alemayehu, Ipas (Ethiopia), Ethiopia

**Summary of Presentation**

The Ethiopian maternal mortality ratio (MMR) is 673 deaths per 100,000 live births. Approximately one third of this mortality is comprised of women suffering from unsafe abortion. The contraceptive prevalence rate is 14% and unmet need for family planning is 34%.

This presentation discussed the Safe Abortion Care Model, which was adapted from the Emergency Obstetric Care mode. This model presents life-saving signal functions that can be used to treat abortion complications. As a part of this intervention, there need to be safe abortion care facilities distributed across the country. The idea is that if safe abortion services are accessible, affordable and of good quality, women will use them and abortion related deaths might decrease. In 2007, there were 14 basic and 3 comprehensive abortion facilities in Tigray region of Ethiopia. By 2009, this had increased to 32 basic and 6 comprehensive facilities. In 2007, abortion services were provided largely at hospitals but by 2009, they had decentralized and reached health centres as well.

As a result of this intervention, the number of abortion related complications as a percentage of obstetric complications have decreased. However, serious abortion-related complications have increased although the presenter attributed this to record-keeping rather than a true difference in complications. The percentage of abortion patients who received safe abortions increased from 7.3% in 2007 to 59.9% in 2009.

Overall, there has been an improvement in nearly all safe abortion care measures over time. Facilities have improved in their quality of services as well as their distribution and accessibility. Post abortion contraceptive uptake has also been good. If this trajectory continues it will help Vietnam meet the Millennium Development Goals.

**Discussion**

There was a lively discussion that followed the presentations. Regarding the South African presentation, there were questions about condom uptake and also concern about so many women going back to the method that they were using when they became pregnant. By way of explanation, the presenter explained the primacy of condom promotion as coming from the HIV epidemic. She also cited inadequate counseling and a lack of supplies as responsible for women using the same method pre and post abortion.

One audience member inquired as to why individuals under 18 were excluded from the Ghanaian study. Sexually active youth are an important group to capture when dealing with issues of abortion. However, by way of response, the presenter indicated that the Johns Hopkins ethics review board has special stipulations for those considered not to be adults. Therefore, it was easier to conduct this research focusing only on those above the age of 18. Audience members also wanted to know whether the discrepancy between the TFR and the CPR was attributable to abortion. Although it is plausible that it could be periodic abstinence, the more likely explanation is high levels of abortion.

Addressing the last presentation, people were intrigued by the increase in severe abortion related complications. They wanted to know the types of complications and whether it was possible that the caliber of the staff had changed. Another audience member wanted to know why those using family
planning in the past had stopped. The presenter responded that the increase in severe complications was likely a fluke of record keeping and not a real phenomenon. This is especially true since all of their other measures improved. In terms of stopping family planning, the majority of women did not stop on their short-term methods. Instead due to user error, the methods failed, resulting in an unintended pregnancy.

**Key Recommendations**

**Paper One**
- Improve counseling for abortion patients- especially on long-term methods.
- Conduct long-term follow-up of patients post-abortion.
- Increase family planning options through advocacy.

**Paper Two**
- Focus on supporting abortion patients in Ghana who are often independent.
- Increase awareness of the legality of abortion in Ghana.
- Promote family planning.
- Provide safe access to abortion.

**Paper Three**
- Provide access to all family planning methods and safe abortion
- Reach out to single, low-income, young women to increase knowledge about contraception

**Paper Four**
- Promote the use of long-term methods in Vietnam.
- Gain access to Mifepristone.
- Reduce use of ultrasound for pregnancy confirmation.
- Put quality checks into place for abortion services.

**Paper Five**
- Continue to implement and spread safe abortion care throughout Ethiopia.
- Maintain close record-keeping to track severe complications.

**SESSION C07: FAMILY PLANNING FINANCING**

*Moderator(s):* Susan Mpanga Mukasa, PACE, Uganda; Alex Todd-Lippock, USAID, USA

**Presentations**

**Paper 1: Global Fund Financing of Contraceptive for RH Commodity Security in Rwanda**
*Presenter: Dr. Fidel Ngabo*, Rwanda Ministry of Health

**Summary of Presentation**
The presenter explained that the demand for contraceptives in the developing counties is growing. This results in a huge challenge in terms of purchasing contraceptives. The study discussed condom financing, justifying the need for integration, and procurement of contraception and its application for generating demand. In 2006 The Global Fund committed to financing HIV and RH programs up to $15.6 billion in 140 counties. $2.5 million of this money goes to Rwanda ($ 800,000/year for 2 years). The money was for training providers and supporting supervision. The Global Fund financed up to 21% of the private sector for Family Planning in Rwanda. The Global Fund had historically financed condoms; however, Rwanda was the first country to benefit from The Global Fund financing of other kinds of contraceptives. Malawi was another beneficiary.

**Paper 2: Private Sector in Vertical Family Planning in Rural Communities in India**
*Presenter: Mr. Gopi Gopalakrishman*, World Health Partners, India
Summary of Presentation
The presenter shared 15 years of experience with the World Health Partners project in the northern state of India and lessons learned in providing health services to the rural communities by use of private partners. The private sector presents a huge opportunity for service delivery where the public sector is dysfunctional or inefficient. There was a huge challenge of service delivery of reliable supply of contraceptives. Thus logistics was a key driver for the inclusion of the private sector. People sell assets to access curative services but they do not feel compelled to do the same with contraceptives. Therefore, it is necessary to provide contraceptives as close to the clients as possible. The results of this intervention were dramatic: an estimated 48,330 unwanted pregnancies averted; 59,000 couple years of protection provided in 7 months. These compelling results call for the integration of Family Planning and curative services, especially in the rural communities.

Paper 3: Coverage of Social Marketing of Family Planning Products in Nigeria: Findings From a Measuring Accesses and Performance Survey
Presenter: Dr. Chinazo Ujuju, Society for Family Health
Summary of Presentation
This study investigated contraceptive social marketing for the rural poor and the vulnerable in Nigeria since this group often lacks access to modern contraception. The study employed Global Positioning System (GPS) and Lot Quality Assurance Sampling (LQAS) to estimate coverage and quality of contraceptive productive. SPSS was used to merge data. Standards for access was used for pills (20 minutes in urban and 30 in rural); and condom (5 minute in urban and 10 in rural). The results revealed that access to pills, condom and DMPA increased by 68%, 68% and 49% respectively. Overall there was a large volume of contraceptive products and they reached the target users (the poor and vulnerable). This method is quick and simple in expanding access to Family Planning.

Paper 4: Comparison of Cost Effectiveness of contraceptives in 13 USAID Office of Population and Reproductive Health priority Tier 1 Countries
Presenter: Ms. Barbara Janowitz, Family Health International, United States of America
Summary of Presentation
This study assessed the impact of introducing a new, low-cost, effective contraceptive – the implant. The cost-effectiveness of the Family Planning method was measured using couple years of protection. This measure was established by dividing the unit service delivery cost by the couple year protection for that method. The couple conversion factor was used as data source. It was assumed that for service delivery, all providers will be trained and that all methods are equally acceptable by the client. Couple year protection was incurred in demand creation, training providers and service delivery per couple years of protection for that method. The results revealed that, the cost of delivering IUD was low in comparison to oral contraceptive and DMPA.

Paper 5: Financing Family Planning through sales revenue in DKT program countries
Presenter: Mr. Phil Harvey, DKT International, United States of America
Summary of Presentation
The presenter explained that although governments are the largest provider of contraceptives, in many counties, the contraceptive needs of the poor and vulnerable are increasingly being met by the private sector through social marketing. Programs should aim at maximization of revenue for sustainability while not compromising on the poor and the vulnerable, who may be unable to afford the costs of contraceptives. DKT has increased revenue (sales) and CYP. Programs have expense – revenue/sales gap that needed to be met by donors. In DKT, 70% of program expenses are financed from client venues and the donor community finances the remaining 30%. Cross-subsidy and re-imbursement are some of the mechanisms of Family Planning financing. Cost of provision of services should not increase beyond 0.25% of the gross income.

Discussion
Donor subsidies continue to be required in developing countries where the unmet need is the highest.
Key Recommendations

- Contraceptives need to be made available nearest to the clients as is Coca-Cola soft drinks.

SESSION D07: ADDRESSING THE FAMILY PLANNING NEEDS OF PEOPLE LIVING WITH HIV

Moderator(s): Juliana Lunguzi, UNFPA, Malawi; Lana Rae Dakan, Packard Foundation, USA

Presentations

Paper 1: Improving Family Planning Choices for People Living with HIV in Zambia.
Presenter: Uttara Bharath Kumar, Health Communication Partnership, Zambia
Summary of Presentation
The presenter introduced Zambia as a country with an HIV prevalence rate of 14.3%. This means that about 1.5 million people are living with HIV/AIDS. Sixteen percent of pregnant women are HIV positive and 40% of babies born to them will be infected if there is no PMTCT intervention. Family planning use is estimated at 41% and at least 27% would like to use family planning but are currently not using it. A large number of people living with HIV/AIDS (PLWHA) are in dire need of accurate information to help them to make good reproductive health decisions and choices. However, this information is often lacking. Thus, the Health Communication Partnership (HCP) in 2006 conducted a qualitative study about how fertility related decisions are made in high HIV prevalence settings. The study found that there is a desire for fertility among PLWHA. The low levels of information about FP and fertility choices mean that people resort to myths and misconceptions such as the myth that FP affects the effectiveness of ARV therapy. Stigma was also high for HIV positive women who become pregnant: community members seem to think that HIV/AIDS disqualifies these women from having children. The study suggested the need to create a basic information package of FP, HIV/AIDS treatment, and PMTCT information to promote partner communication and to create a compassionate enabling environment of support groups and non-judgmental service providers. Zambia is a country with shortages in the healthcare workforce. HCP and stakeholders came up with a communication strategy through the use of a consultative process. This led to the development of a video documentary called “Our Family, Our Choice”. It is an innovative tool with consistent messages and characters in the video model positive behaviors. The video was developed in English and 7 common Zambian languages. A discussion guide for facilitators and take-home leaflets for clients accompany it. The video and focuses on how PLWHA can use family planning to delay pregnancy. Emotional support is provided for couples that decide for and against having children, with balanced views as much as possible. The video dispels rumors about FP use among PLWHA and provides a platform of discussion on these pertinent issues. It guides PLWHA to make informed decisions. The video has been used countrywide and feedback shows an overwhelming demand for the information in the video by PLWHA and those who work in this field. Nurses use it to conduct health education sessions with clients. Early results show that of individuals who tested for HIV and were exposed to the video, at least 70% were using family planning services. The presenter concluded that not all PLWHA are benefiting from FP services and that the exposure to the video increases FP service utilization. There has historically been a gap of innovative tools such as this to use at community and health facility level. This tool creates expectations for service delivery and increases knowledge for care seeking.

Presenter: Assefa Seme Deresse, SPH Addis Ababa University, Ethiopia
Summary of Presentation
The presenter introduced Ethiopia as the second most populous country in Africa. He noted that about one million people in Ethiopia are living with HIV and that women are most affected sub-population. Typically, sexual reproductive health (SRH) needs of people in a same setting should be the same, however with the advent of HIV/AIDS and use of ARV therapy this has changed. The presenter suggested that there is increased sexual desire (libido) among People Living with HIV on ART therapy. A cross-sectional study conducted February-March 2007 in five hospitals of Southern Ethiopia assessed
sexual and reproductive health needs and preferences of PLWHA who had been on ART for at least six months. A structured and pre-tested questionnaire was used to obtain information about respondents’ desire to have children in the future. The majority of respondents were married females. Data entry and analysis was done using SPSS. The results indicated that one-third (33%) of the respondents wanted to have more children. The study concluded that HIV status does not affect sexual and reproductive health needs of the PLWHA. The study recommends more awareness about PMTCT among PLWHA and adoption of children as an alternative strategy.

**Paper 3: Harm-reduction Applied to Reproductive Health Counseling for HIV-affected Couples who Choose to Conceive Children.**

**Presenter:** Lynn T. Matthews, Beth Israel Deaconess Medical Centre, Boston.

**Summary of Presentation**

The paper focuses on measures and strategies for minimizing HIV transmission among PLWHA to their partners and children. The presenter noted that most new HIV occurrence is among women. The presenter observed that in this era of ART, there is increased desire for PLWHA continue bear children thus a need to make conception, delivery and upbringing safer. Therefore, family planning is critical in ensuring better results in maternal health and pediatric care because large family size can exacerbate an already overstretched household struggling to deal with HIV/AIDS. Traditionally PLWHA are advised not to have children but PLWHA have strong reasons for having children that include; social and economic reasons, desire for a normal life and cultural value of fertility. The presenter stated that longitudinal data has show that HIV transmission risk can be reduced to acceptable levels through numerous strategies including; Educating PLWHA to enable them appreciate the risk to make informed decisions regarding having children, making it safer to have children plus providing on-going counseling and support, male sperm washing (only done at fertility centers), female home artificial insemination using a syringe, pre-treatment of STIs, and male circumcision. Other measures include viral repression for those on ART and behavior modification to ensure PLWHA are started on treatment early and encouraged to adhere. The presenter noted that there are numerous challenges to harm reduction strategy that include; risk compensation, poor infrastructure and limited resources especially in Less Developed Countries (LDC’s) where ART is not yet accessible to all who qualify for treatment. The presenter concluded that many times, PLWHA want to have children and that the risk reduction of HIV transmission is vital.

**Paper 4: Factors Influencing Contraceptive Choice and Discontinuation Among HIV-Positive Women in Rio De Janeiro, Brazil**

**Presenter:** Monica S. Malta, Oswaldo Cruz Foundation, Brazil.

**Summary of Presentation**

The presenter introduced Brazil as a country that has registered a relatively low HIV prevalence rate at 0.61%. Brazil has an open HIV/AIDS prevention strategy characterized by a vibrant mass media campaign, and treatment strategy whereby ART is offered at no cost through the public health system. Contraceptive use remains an issue of concern among HIV-positive women in Rio De Janeiro where 6.9 pregnancies/100 woman-years occurred between 1999 and 2003 among HIV-positive women on ART. The last National Household Survey found the use of condoms low and the explanation was that partners still trust each other to be safe. Women are the most affected by HIV in Brazil. Nearly all women use contraceptives because they find condom difficult to negotiate. Pills are rarely used because mothers say they forget to take them routinely as prescribed. Based this background information, a qualitative study was conducted in by Oswaldo Cruz Foundation among HIV-positive women between 18-40 years of age to determine factors for contraceptive choice and discontinuation. All the respondents at least had one child. The majority of women preferred oral contraceptives and injectables, but these were not readily available. The male condom is key because of its dual purpose as FP method and HIV prevention tool but women complained of the difficulty to negotiate condom use, which normally results into domestic violence. Women who practiced sterilization later regretted when they found out they can’t have children with their new partners. The study concluded that that HIV status has some impact on women’s choice and discontinuation of contraceptive use but it is not the key factor. It is necessary to have comprehensive counseling package for women on ART to enable them make informed decisions. A wide range of FP methods should be made available to give women a variety from where to choose. There is need for mass education about condom use and other FP methods with emphasis on rights and
responsibilities. The study limitations included; lack of comparative groups, small sample size. To address these limitations, the study team visited and interviewed women in different public health facilities.

**Paper 5: Factors Influencing Contraceptive Choice and Discontinuation Among HIV-Positive Women in Kericho, Kenya**  
**Presenter:** Samuel K. Sinei, Walter Reed Project Program  
**Summary of Presentation**  
By way of background information, the presenter noted that HIV in Kenya is mainly transmitted through heterosexual contact. The HIV prevalence rate in Western Kenya District of Kericho is estimated at 6-14% among adults and this goes as high as 19% among women. The contraceptive Prevalence Rate (CPR) is estimated at 46%. There is an increase in HIV transmission among pregnant women. A qualitative study coordinated by Colombia University was carried out in Kericho District with objectives to determine the impact of gender on contraceptive utilization among PLWHA in Kenya and to assess the level of integration of FP/SRH and HIV/AIDS services. The study was part of an international study conducted in three countries: Kenya, Brazil and South Africa.

Data was collected using a questionnaire about ART usage, fertility history, fertility desires and contraceptive usage. Focus Group Discussions were organized to obtain in-depth information about the subject. Data was coded and using grounded theory was put in themes to determine the factors. The presenter noted several themes and key findings. In terms of fertility and menstrual philosophies, it was noted that people had inaccurate information about fertility and timing pregnancies and medically inaccurate beliefs. In terms of gender roles, men tended to refuse the use of condom on the claim that it reduces pleasure. Regarding HIV diagnosis, women became assertive. For example some refused to be inherited after their husband’s death. The themes generated on contraceptive choice some participants indicated that contraceptives reduce libido, menstrual changes lead to method discontinuation, noted that male participation in decision making about use of contraption is crucial. Limitations of the study included a potential bias because most respondents were widows and because focus group discussions were limited on themes. In order to reduce bias, female health workers were used to collect data.

**Discussion**

**Kericho-Kenya study:** Were young people included in the study and was there difference in findings between adolescents and adults? The presenter said it was hard to find young women aged 18-35 with HIV in the study site. In addition, adolescents below 18 years could not be included for consent and confidentiality reasons.

**Zambia Study:** Do couples switch to different methods? The presenter responded that this particular aspect was not studied but can look at it in the future and added that the Video encourages young people to get tested before marriage. VCT can factor into FP choices.

In the video do you promote dual methods like condoms or consider hormonal methods? The presenter said the video presents method mix especially those available in Zambia but people are encouraged to visit a trained health worker for further counseling to select the suitable method.

A participant on a point of information stated that WHO eligibility criteria is more precise for FP selection among HIV-positive women but ideally any method can be used. This participant participants to visit WHO stall to get a CD to learn more about appropriate methods for HIV-positive women.

**Brazil:** A participant wanted to know the factors behind 80% CPR in Brazil for other countries to emulate. The presenter explained the factors as open approach, political support and open media campaign, condoms are found in all public places including schools and all groups including PLWHA and those on ART are targeted.

Why are you concerned about permanent FP especially sterilization in Brazil? The presenter explained that in Brazil young women are more open and accept sterilization on their choice. However, over the
years have observed a trend where young girls of 23 years are going for sterilization because they are HIV-positive without giving themselves adequate time about this decision, because with advances in PMTCT these can produce healthy children in future. This justifies a need for an intervention.

**Ethiopia:** As noted that HIV-Positive women are bearing children what is the status of integration of family planning services in HIV/AIDS care? The presenter explained that as part of HIV/AIDS care services PLWHA discuss with health providers on whether to have or not to have children. Those found pregnant at the time of the study were mainly stable couples in their 40’s the growing number of discordant couples in Africa calls for more studies and interventions for people to test for HIV before having children.

**Key Recommendations**

- There is need to support the development of innovative and effective communication tools such as HCP video in Zambia to fill apparent information gap on family planning choices in the context of HIV/AIDS.
- Since HIV/AIDS does not affect Sexual Reproductive Health needs of PLWHA including the desire to have children, there is need to integrate FP into HIV/AIDS care services, create more awareness on safer ways to have children such as through PMTCT and explore other strategies such as child adoption.

**SESSION E07: MATCHING FAMILY PLANNING/REPRODUCTIVE HEALTH SERVICES TO UNMET NEED**

**Sponsor:** Jhpiego

**Presentations**

**Paper 1: The case for PPIUD- Addressing Demand for Long Term Methods in Kenya and India**  
**Presenter:** Jeffrey Smith, Jhpiego, United States of America

**Summary of Presentation**  
The postpartum IUCD (PPIUCD) provides an effective, long-term method to women who are already at a facility receiving care. The presenter described several prior studies that have examined PPIUCD. Immediate postpartum insertion of IUCD was associated with higher uptake and lower costs. The evaluation of two PPIUCD programs at Jhpiego, one in Kenya and one in India, were the focus of the presentation. The Kenya program was implemented in a district hospital, whereby nurses and midwives typically inserted the PPIUCD via manual insertion. The India program, on the other hand, was implemented in a teaching hospital, whereby doctors typically inserted the PPIUCD. The type of insertion of the PPIUCD varied by country due to the types of service providers trained in each of the countries. Insertion of PPIUCD increased slowly overtime. Recommendations for service delivery requirements include a competency-based training, quality counseling, minimal supplies, and client follow-up within the first three months post-insertion.

**Paper 2: Integrating Family Planning Into Maternal and Newborn Care in Northern Nigeria**  
**Presenter:** Tunde Segun, Jhpiego, United States of America

**Summary of Presentation**  
This study was conducted in Northern Nigeria where the context differs from other parts of the country. The presenter noted that family planning is often not discussed in Northern Nigeria. In-depth interviews were conducted with policy makers and service providers in addition to community participatory exercises to understand familiarity, perceptions, barriers and experiences with integrated services of family planning into maternal and newborn care. At the policy and management level, antenatal care was considered the gateway to other services. From the providers’ and the community members’ perspectives, antenatal care was considered the most important and most highly used service. Family planning often received a low ranking relative to other services. Barriers to services included religion, education, a lack of
understanding, women’s need for husband’s permission and cost and transportation. It is evident from the results that not all services are equally valued. The approach of integrating family planning with maternal and newborn care was well accepted, however, barriers exist.

Paper 3: Meeting Reproductive Health Needs of Marginalized Urban Populations in Kenya
Presenter: Jane Otai, Jhpiego, United States of America
Summary of Presentation
The presenter described a program conducted in two Nairobi slums, Korogocho and Viwandani. An adapted performance and quality improvement approach was utilized to involve both the service providers and communities in identifying their problems, desires and strategies. Both facility and community-level interventions were implemented. The facility-level interventions included training providers in family planning, identifying champions in health facilities, facility exchanges, outreach, continuous medical education and support groups. Community-level interventions include mapping services, advocacy, and training. At the community level, there was an increase in empowerment, dispelling of myths, collaboration with health facilities and an increase in family planning acceptance. This program was able to reach a large population and involve community members. The presenter noted that there is a need for donors to be more flexible in their requirements to allow for unanticipated needs and interventions.

Paper 4: Family Planning and PMTCT Integration: Baseline Situation in Morogoro, Tanzania
Presenter: Chrisostom Lipingu, Jhpiego, United States of America
Summary of Presentation
This baseline assessment was conducted in Morogoro, Tanzania with the intention of guiding the establishment of a program of comprehensive postnatal care services. Antenatal care is highly attended by women in Tanzania, however, there is less focus on postnatal care. The assessment was carried out at the facility and community levels and included observations, interviews, audits, record reviews, and focus group discussions. It was discovered from the assessment of 12 facilities that PMTCT services are mainly offered during antenatal care and intrapartum care. Additionally, providers’ knowledge of family planning was out-of-date and no family planning counseling was offered to postpartum women prior to discharge. At the community-level, postpartum women, male partners, and community volunteers participated in focus group discussions. These respondents demonstrated high knowledge of antenatal care but a lack of knowledge regarding PMTCT and postnatal care including postpartum family planning. Stigma against people living with HIV/AIDS also persists. Recommendations for program activities proposed by the presenter include establishing PNC guidelines with postpartum family planning (PPFP), training providers in PPFP, training community health workers, and monitoring and evaluating activities.

Discussion
A couple of questions were raised regarding a comment made by the second presenter. In the presentation, the presenter said that a barrier to contraceptive use is that some providers require that a woman have a note from her husband. A member from the audience stated that she has heard of this in Kenya where the note was a way of encouraging couples to discuss family planning. The second presenter clarified that this was not the case in Northern Nigeria and that in Northern Nigeria the note represented the husband’s permission.

Another audience member asked the fourth presenter if the program would target HIV positive women who are not yet pregnant with family planning services. The presenter appreciated the importance of this need, however, he stated that they are only focusing on postpartum family planning because this was identified as a major gap that was not being addressed by other organizations in the area.

The third presenter had emphasized how important and successful their program was in involving youth and an audience member wanted more information about the specific approach used to get youth involved. The presenter explained that youth were in need of services especially because they felt interrogated by health providers. In order to overcome these barriers they trained providers on youth-friendly services, organized exchange visits with other facilities, organized youth community-based
organizations, and provided youth with a popcorn machine as an income generating activity. It was also noted that youth distribution of contraception was resisted at first, especially with religious leaders. Using data to talk with religious leaders helped change their attitudes.

**Key Recommendations**

- With activities in Kenya and India, PPIUCD is increasing. Several recommendations for successful service delivery include competency-based training, good counseling, minimal supplies, and client follow-up in first three months when IUCD expulsion is the most common.
- The study on the integration of family planning into MNCH services in Northern Nigeria found that integrated services are highly desirable by women who live further away from the clinic.
- The diverse risks that are prevalent in urban slums in Kenya lead the presenter to highlight the need to address multiple issues including water and sanitation, rape, and income generation. Additionally, donors should be more flexible in their requirements.
- The program in the Kenyan urban slums also found success in establishing community-facility linkages. This approach is recommended as a way of improving utilization of health facilities.
- The fourth presenter recommended that facilities establish postnatal care guidelines and train providers in order to promote the integration of family planning and PMTCT into postnatal care services. In addition, training community health workers was recommended.

SESSION F07: SERVICE DELIVERY FOR INJECTABLES, IMPLANTS, AND ORAL CONTRACEPTION

*Moderator(s):* Angela Akol, FHI, Uganda; Sheila Nyawira Macharia, USAID, Kenya

**Presentations**

*Paper 1: Assessment of Implant removal practices: Early Assessment in Ethiopia.*

*Presenter: Altaye Kidane,* Family Health International/Ethiopia

**Summary of Presentation**

The purpose of this study was to assess reasons for, and rates of, implant removal in Ethiopia, where these methods have recently grown in popularity. Between June and September, 2008, data were collected from 15 Family Guidance Association of Ethiopia clinics and 14 Marie Stopes International clinics in six geographic regions of Ethiopia. The study team interviewed women seeking implant removal and held both interviews and focus group discussions with providers. During the study period, 619 women had implants removed and were surveyed. 75% of these women were aged 25 years or older, and 54% had at least 3 previous pregnancies. Only 2% of women had early removals, or had their implant removed 6 or fewer months post-insertion. The most common reason given for removal was disturbance of menstrual regularity (28%), followed by desiring a pregnancy (27%) and product expiration (25%). Most implant removals took less than 10 minutes to complete, but providers indicated that limited time for counseling during insertion was a problem. Providers also indicated that women often complained about both side effects and limited time for counseling about potential side effects.

*Paper 2: Tasking shifting: The case of Implants in Kenya*

*Presenter: Maureen Kuyoh,* Family Health International, Kenya

**Summary of Presentation**

As part of the strategy to reinvigorate Kenya’s family planning program, the Ministry of Health has recently begun focusing on long term contraceptive methods such as sub-dermal implants. In 2002, 50,000 Norplant implants had been procured through USAID funding and were near expiration. At this time, only medical doctors could insert Norplant. Due to a shortage of physicians, Norplant was available for insertion in very few facilities around the country. Under the leadership of the Ministry of Health, a task force was formed to prevent these implants from expiring before being used. First, this task force repealed the policy that prevented lower cadres of health workers from providing implants. The Ministry of
Health then provided cascade training to these health workers, starting with trainings of trainers. Between March – June, 2002, 400 nurses and clinical officers were trained to insert and remove Norplant. During this time, 40,000 women obtained Norplant insertions, averting the crisis of expiring contraceptive stock. By 2008, over 1,000 nurses and clinical officers were trained in Norplant provision, and the number of facilities offering this service increased from 72 in 1995 to 1,300 in 2008. However, stock-outs, the need for continuous training of providers and the relatively high cost of implants remain program challenges.

**Paper 3: Bringing their method of choice to rural women: Community based distribution of injectable contraceptives in Tigray, Ethiopia**

**Presenter:** Ndola Prata, Bixby Center for Population, Health and Development, University of California, Berkeley

**Summary of Presentation**

This study tested an intervention in which community-based reproductive health agents (CBRHAs) were trained to provide injectable contraceptives in Tigray Region, Ethiopia. The aim of the research was to examine the CBRHAs’ ability to adequately provide injectables in rural areas. 976 women were enrolled in the study, and were assigned to a study arm based on the type of provider they chose. 59% of women received an injectable contraceptive from a CBRHA, while 41% received them from clinically trained health extension workers (HEWs). Surveys were administered to women at enrollment, and after their first and second injections, or at three and six months post-enrollment. Participants’ median age was nearly 30 years, and 91% of women were married. Among first-time family planning users, 65% were recruited by CBRHAs. Most women in both CBRHA (63%) and HEW (70%) groups gave “convenience” as their main reason for choosing injectable contraceptives. More CBRHAs than HEWs offered condoms to their clients at the time of both first and second injections, with around 80% of women served by CBRHAs receiving counseling on condoms at both timepoints. No injection-related morbidity was observed for either provider type, but a few more CBRHA patients reported side effects. Among all women, the authors observed 82% contraceptive continuation at 3 months and 74% at 6 months. Discontinuation rates were significantly higher among HEWs compared to CBRHAs, and the most common reason for discontinuation was side effects.

**Paper 4: Addressing unmet need for family planning in Nigeria through a comprehensive package of services**

**Presenter:** Fatima Bunza, Pathfinder International

**Summary of Presentation**

This presentation described the COMPASS (community participation for action in the social sector) in Nigeria. This project was delivered by nine partners, led by Pathfinder, and was implemented in four states, concentrated in northern Nigeria. The intervention package included family planning, child health and basic education and was designed to expand participation and ownership of health care at community level. The project partners subgranted to 13 local NGOs to conduct community outreach and involve communities in assessment, planning, implementation and evaluation. In particular, Muslim religious leaders were involved in assessment and planning for the family planning and reproductive health component. As part of the project, 98 health facilities were renovated to provide family planning services, and 712 facilities were equipped and supplied with contraceptive methods. Additionally, 6,400 providers were trained in family planning. The project also supported three teaching hospitals in training clinical providers on long-term and permanent methods. National family planning guidelines were reprinted and distributed to providers. In an effort to reach adolescents, youth-friendly services were designed in 40 of the facilities. Contraceptive prevalence in the intervention states increased from 9% in 2005 to 32% in 2007. The largest increase was observed in Lagos, where contraceptive prevalence increased from under 15% in 2005 to nearly 40% in 2007.

**Discussion**

One audience member asked the presenter from the Bixby Center whether data from her study could be used to predict how long women with side effects three months after method initiation would use injectables. The presenter said the numbers in her study were too small to construct a profile of
continuers and discontinuers. It may be feasible in the future with the growing popularity of community-based distribution.

Another audience member asked the same presenter from the Bixby Center how well trained the CBRHAs were in understand the anatomy of giving injections. She wondered whether the CBRHAs needed prior medical training or practice. The presenter replied that they were careful to preserve the quality of services when training the CBRHAs. CBRHAs were trained in basic biology and side effects. All staff members had to be injected (with saline) by each CBRHA before they could graduate from the program.

Another participant asked the presenter from the Bixby Center whether or not the Ethiopian CBRHAs were paid for their work. She commented that volunteer work causes women to leave their homes and lose home work-time. This could make poverty worse for women and their families. The presenter replied that injectable recipients pay a small fee for injectables and the CBRHAs keep the profit from their sales. The project paid for the CBRHAs' first round of injectables, but they now buy their own stock. This also provides an incentive for good quality of care.

A participant from Sierra Leon commented that they can't meet the demand for tubal ligation because of the shortage of trained providers. They are trying to train community health officers to perform the service. He wanted to know if anyone in the audience knew of others trying to do this. One of the presenters replied that Mozambique is doing something similar. They are calling the providers surgical technicians, and they can also do C-sections.

Last, an audience member asked the presenter from the Bixby Center if they were doing any work on the demand side for injectables. The presenter replied that CBRHAs are also creating awareness about injectables in the communities they serve. Altaye Kidane from FHI also commented that health extension workers are creating awareness through the government’s program. Fatima Bunza from Pathfinder International added that Johns Hopkins University’s Center for Communication Programs was one of the primary partners in their program and focused on demand generation.

**Key Recommendations**

- Comprehensive counseling on side effects of longer term methods is needed. Providers may need more time to do this adequately.
- Task-shifting increases access to family planning methods but should be done in tandem with commodity procurement to meet increased demand.
- Community-based distribution of injectable contraceptives can increase access in many developing countries where injectables are the most popular contraceptive method.
- Faith-based organizations can help to increase community support for family planning methods.
- More male involvement in helping women to procure longer-term methods is still urgently needed.

**SESSION G07: SERVICE PROVISION ASSESSMENTS TO STRENGTHEN FP PROGRAMS**

*Moderator(s):* Anne Cross, ICF Macro International, USA

*Presentations*

*Paper 1: Support systems for maintaining or improving family planning services in Africa*

*Presenter: Frederick Katumba,* Demographic and Health Surveys at ICF Macro International, USA
Summary of Presentation
The presenter first explained what SPA is all about and how it differs from DHS. SPA looks at services, systems, resources and infrastructure and collects information using facility audit questions, observation checklist, exit interviews, provider interviews and others (country dependent e.g. Uganda information from District Health Teams). SPA gives information on input, process (detail) and service output while DHS is concerned with intermediate and long term outcomes such as morbidity and mortality. This study assessed infrastructure and resources for providing quality FP services using information from latest SPA of Kenya, Uganda, Egypt, Ghana and Tanzania. All the countries had in place FP infrastructures and resources; although inadequate for quality FP service provision, for example no country reaches 50% when all the necessary items for provision of quality FP are considered. In Uganda clients cards was the most missing item from the health facilities, this has not been printed for sometime. In the area of pelvic examination all country performed poorly except Egypt, the rest are less than 30% the worst being Uganda where only 1% of facilities have in place all that is necessary for pelvic examination. The lack of these items that look trivial can greatly affect FP quality service provision.

Paper 2: Common National and Subnational Flaws in Management Practices of Family Planning Services in Africa


Summary of Presentation
The presenter added another dimension in the difference between DHS and SPA: DHS as being assessment for demand while SPA assesses supply. SPA collects MCH/FP information e.g. FP information deciphering by service providers, availability and functionality of equipments, supplies and system capacity. Observation of consultation to assess adherence to international/national standard and client exit interview are done. This study compared the management practices for quality FP services provision at National and subnational level of 5 countries (Ghana, Rwanda, Uganda, Kenya, Tanzania) using information from their latest SPA.

Effective management system is a prerequisite for a good FP provision. Some of the management indicators assessed included, client registers, In-service training (IST), supervision and availability of guidelines. Record were fairly up to date in government facilities while most private facilities don’t have records on FP users, this is the picture across all the countries. There are huge variations between countries and within countries and facility ownership on user fees but in general user fees are higher in urban settings and private facilities have clear charging procedures compared to government facilities. These have effects on FP service uptake. Supervision of staffs and facilities is done well across countries, with all countries scoring over 60%. Of concern is the in-service training of service providers with only Ghana reaching 50% where facilities have providers trained in the last six months prior to the assessment.

Paper 3: Measuring quality of family planning services using Services Provision Assessment Surveys

Presenter: Rathavuth Hong, Demographic and Health Surveys at ICF Macro International, USA

Summary of Presentation
The presenter noted that the definition of quality of care is dependent on personal position; client, service provider, policy maker or programmers. In as much as agreement exists for improving quality of care there is no agreement on how quality levels can be measured. The objective of the this study was therefore to use SPA to develop index of quality for FP (IDXQ-FP) and use it to examine the difference in quality FP services provided by geographic, level and ownership of facilities in Egypt using data from SPA 2002 and 2004. IDXQ-FP was constructed by creating four components using 21 items of FP in the SPA this is constructed to represent both clinical and management issues. The four components are; counselling, contraceptive supplies, examination room and management. Under each component there are different items. IDXQ-FP showed only marginal difference between 2002 and 2004 in Egypt. This means that IDXQ-FP is stable and can be used to assess the quality of FP services given that changes in the quality of service provided by a facility were unlikely to change dramatically over a two year period. IDXQ-FP was also used to evaluate the Gold Star (GS) program in Egypt. The IDXQ-FP for facilities that
were in the GS program was compared with those that were not in the GS program. GS was established by the National Family Planning (NFP) Department of Egypt using USAID funding. The supported facilities had to meet 102 criteria for FP, they were then awarded GS certificate. The facilities received support from the NFP with aim of promoting the provision of quality FP services. IDXQ-FP for GS facilities was on average better than non GS facilities.

**Paper 4: Missed opportunities: Monitoring contraceptive supplies and stockouts**

**Presenter:** Dr Paul Ametepi, Johns Hopkins Center for Communication Programs (CCP)

**Summary of Presentation**

The study demonstrated that while a substantial number of facilities report offering FP methods on 5 or more days per week, stockouts are common and facilities do not always have all the methods available to offer to clients. The study used information from the recent SPA of Uganda, Rwanda and Tanzania to shed some light on FP service provision. In all the countries, over 90% of facilities reported to be offering modern FP methods and the commonest methods being combined oral contraceptive pills (COC), progesterone only pills (POP) and male condoms. Despite the fact that over 90% of facilities in Uganda, Rwanda and Tanzania reportedly offer COC, only 79%, 69% and 85% had them on the day of the survey respectively. Many facilities in Uganda had Intra-uterine contraceptive devices (IUCD) compared to other countries but even this was only available in about 50% of the facilities reportedly offering them. The percentages of facilities with all the modern methods available are very low, for example only 15% of facilities in Rwanda had all the methods available. FP services are offered in Rwanda and TZ by public facilities only, while in Uganda both public and private facilities offer FP services. Proportion of facilities offering FP services are similar in TZ, UG and Rwanda at 76%, 79% and 71% respectively. In Uganda the use of female condom is very low at about 5% only compared to other countries in this study. FP services are not offered in all facilities, even in facilities offering ANC, FP is rarely discussed by health workers during health education to clients, this and stockouts of modern methods have implication on uptake of FP services and contribute significantly to the missed opportunities for FP by the clients.

**Discussion**

SPA seems to be a better tool for assessing service provision, though the main concerns raised by some of the members in the audience include aspects of information collection, it reliability and specifically there was a heated debate concerning client exit interview. One participant from Uganda said one time they were gathering information from clients seeking their view on the services they had got from the facility and this they were doing it after the client has got the service, the answers they got contrasted dramatically when the went to the communities. They concluded that getting information from clients within the facility premises may not yield the actual information. This was disputed by a participant from Kenya who said if a social scientist is trained well and collects information from clients after the service not within the building but at convenient corner of the facility, it achieves reliable information. Another area that stimulated questions from participants though with no answers was the very low female condom use in Uganda, yet this is one of the methods where women have controls over, not only for family planning but also in the prevention of STI/HIV

**Key Recommendations**

- Capacity to provide quality FP services varies from country to country.
- Lack of a single item in the FP service provision compromises the overall quality of FP service.
- Capacity to provide FP service can be improved by provision of these items, which are not very costly.
- In-service Training is not being emphasized, yet technology in the medical field is very dynamic.
- Huge variation within and without countries exist on user fees and this affects FP uptake
- A number of health facilities do not offer FP services and those that offer usually do not have all methods available for range of clients.
- Management practices in FP need to be improved.
• IDXQ-FP provides ways of further analyzing SPA.
• SPA collects reasonably good information on health care facilities and can be used to evaluate FP programs, but when the interval of assessment is short it is not possible to observe changes in the service delivery.
• Finally, the presenters hope these information will be an advocacy tool for FP, targeting Policy makers especially members of Parliament and planner.

SESSION A08: NATIONAL FAMILY PLANNING POLICY AND ADVOCACY II

Moderator(s): Harry Jooseery, Partners in Population and Development, Bangladesh; Anthony Mbonye, Family Health International, Uganda

Presentations

Paper 1: The Family Planning Effort Index: 81 Developing Countries, 2009
Presenter: Ellen Smith, Futures Group, United States of America
Summary of Presentation
The Family Planning Effort Index is a measure of 31 items that covers four main components: policy context, service provision, evaluation and monitoring, and access to methods. Seven rounds of data collection have occurred with this index since 1972 in over 80 developing countries. The effort scores are used to trace the history and performance of family planning programs and can be compared across countries and overtime. The presenter highlighted the 2009 results but also compared these results with prior years. It was found that the profiles are similar across regions with policy context receiving the highest scores and service provision receiving the lowest scores. There was not a lot of change observed overtime and not all countries improved from 2004 to 2009. Outreach was one of the few indicators that did increase overtime. Contraceptive prevalence rate was highly correlated with access indicators. Negative external factors on national family planning programs include decentralization and shifts in donor funding. These results demonstrate that there is the potential and the need for strengthening family planning programs.

Paper 2: Family Planning Champions: Harnessing the Innovative Advocate
Presenter: Tricia Petruney, Family Health International, United States of America
Summary of Presentation
Champions actively support and promote an issue and are persuasive about it. Champions do not need to be figures of authority and it is important to engage a range of champions along a continuum. The presenter described a Family Health International (FHI) project called the Network of Champions that started in 2004 in several countries. The champions for this project are asked to promote awareness of contraceptive technology and translate research findings. Programs in four countries (Nigeria, Tanzania, Uganda and Zambia) were described further. Key accomplishments ranged from a postpartum family planning protocol being developed in Uganda to reproductive health clinics offering integrated family planning and HIV services in Tanzania. It can be difficult to sustain champions thus it is important to provide some material support as well as open dialogue. Additionally, the presenter emphasized the importance of stakeholder buy-in and recommended involving them from the beginning.

Presenter: Kirsten Krueger, Family Health International, United States of America
Summary of Presentation
The innovation described by this presenter was the administration of injectables by properly trained paramedical professionals in areas with low access to and a high unmet need for family planning. This is a USAID priority strategy that follows a WHO task-shifting framework. The advocacy campaign for raising awareness of the usefulness of this strategy was presented, highlighting accomplishments at the country level (Uganda), continent level, and global level. The components of the advocacy campaign included
convening an advisory team, holding sensitization meetings, presenting evidence-based recommendations, educational tours and tool development. Country-level accomplishments include establishing core teams and champions, conducting a pilot study, and securing new funds. Continent-level accomplishments include holding meetings in numerous countries, expanding to other countries, and changing policies. At the global level, a WHO/USAID/FHI technical consultation was held in Geneva in 2009. Based on this experience, the presenter recommended using data, understanding the opposition’s position, cultivating teams and champions, and knowing the decision-making process.

**Paper 4: Renewing High-level Commitment For FP/RH Policies: An Overview of the Policy Implementation Assessment Tool and Its Uses**

**Presenter: Anita Bhuyan,** Futures Group International/Health Policy Initiative Task Order 1, United States of America

**Summary of Presentation**

This presenter explained the Policy Implementation Assessment Tool (PIAT), a USAID Health Policy Initiative, Task Order 1. Through two questionnaires (for policy makers and stakeholders), this tool helps to identify facilitators and barriers to policy implementation. Eight steps to utilizing the tool are provided ranging from selecting a policy to adapting the questionnaire to disseminating results. Results from Guatemala and India were described. In Guatemala, the PIAT was used to assess the implementation of the RH section of the Social Development and Population Policy. They found that there was a consensus on the importance of the policy; however, there was a lack of coordination of implementation. In India, the PIAT was used for an Integrated Health and Population Policy. The PIAT helped identify a lack of leadership and a human resource shortage. In both countries, the results of the assessment lead to better coordination and improved implementation. The PIAT is flexible, systematic and user-friendly.

**Paper 5: Implementing Sustainable Solutions to Enhance Access to Family Planning Among the Poor in Kenya**

**Presenter: Suneeta Sharma,** USAID Health Policy Initiative

**Summary of Presentation**

This study aimed to improve access to FP and RH services among the poor in Kenya. Market segmentation, system diagnosis, and operational barriers analyses were all employed to understand the barriers to FP access among the poor. From the analyses, it was identified that a lack of male engagement, religion, stock-outs, regional disparities, misconceptions, cultural factors and high costs all contribute as barriers to FP among the poor. The presenter put forth several recommendations for moving forward including incorporating equity goals, mobilization of civil society to advocate for family planning, promoting the representation of poor in committees, organization of high level policy dialogue, working with the private sector and using an evidence-based systematic approach.

**Discussion**

Audience members raised several questions regarding champions, including the characteristics of champions and their ability to translate evidence-based research. The second presenter described that champions were equipped with global evidence on FP/HIV integration and that assistance was provided for monitoring and evaluating their activities. Additionally, it was noted that satisfied users of contraception can be used as champions for community mobilization. The third presenter explained that the relationship between organizations and champions is a two-way street in which information and ideas flow in both directions.

An audience member asked the fourth presenter how one can push for an assessment of policy implementation when there is no will. The fourth presenter explained that in these circumstances, there is a need for advocacy with both the government and civil society.

The remaining questions asked presenters for clarification of methodology and results such as how safe abortion was included in the Family Planning Effort Index. The first presenter explained that there is one question out of the 31 questions that asks the percent of population with access to safe abortion.
Key Recommendations

- Based on the findings from the Family Planning Effort Index, there has not been notable improvement over time. Thus, there is a need for strengthening family planning programs. This index helps identify the strengths and weaknesses of family planning programs.
- Champions require support in the form of material/financial support, process support, social support, and content support. Support of champions can help reduce burnout and maintain motivation.
- Family Health International has employed advocacy strategies at all levels to advocate for community-based provision of injectables. From this experience, it was recommended that data be used as a tool of persuasion and that there is an understanding of the decision-making process. An additional recommendation included reaching out to the opposition and finding where their interests converge with yours.
- Strategies given for improving FP access for the poor in Kenya include mobilizing civil society to advocate for FP, establishing equity goals and approaches, organizing high level policy dialogue, and working with the private sector.

SESSION B08: NOT RECORDED

SESSION C08: PUBLIC-PRIVATE PARTNERSHIPS FOR SUCCESSFUL FAMILY PLANNING FINANCING

Moderator(s): Phil Harvey, DKT International; Carmen Coles, USAID, USA

Presentations

Paper 1: Improving Social Marketing of Female Condoms in Nigeria: Expanding level of Coverage and Quality of Coverage.


Summary of Presentation
The presenter noted that the uptake and utilization of the female condom in Nigeria has been low since its introduction in the 1990’s due to social, cultural, economical and programmatic challenges. Initially, female condoms were placed at public health facilities and not at private clinics. However, the general public does not utilize public health facilities in Nigeria. To determine the status of female condoms in Nigeria, a Measuring Access and Performance (MAP) survey was conducted in the three states of Lagos, Edo and Delta to estimate the level of coverage and quality of coverage. Study results revealed low penetration of the product: in each of the three states, there was low coverage and there was lack of promotional materials and rampant stock outs. In terms of recommendations for the future, the study will guide program re-design to establish a functioning distribution and delivery system. There is also need to improve coverage and develop a social marketing strategy to improve access of the female condoms and create demand through the distribution of promotional materials. The presenter mentioned that training has already begun to improve knowledge and skills of service providers.


Presenter: Jayne Rowan, PSI Myanmar, Myanmar.

Summary of Presentation
The presenter introduced Myanmar as a Less Developed Country (LDC) that has limited access to family planning services. Abortion is illegal in Myanmar and women mainly seek contraceptive services through the private sector. However, these private services are often prohibitively expensive. PSI/Myanmar is providing family planning and reproductive health products through the Sun Quality Health (SQH), a social franchise network of private doctors. The service providers are identified, trained and given IEC
materials, provided with a range of products (including FP methods, safe water, malaria control products) and are expected to adhere to set standards and protocols. PSI/Myanmar uses these social franchises as a cost-effective way to increase awareness and availability of IUD among low-income women living within the catchment area of the SQH clinic. A PSI/Myanmar mobile team and a team of three doctors who are trained in IUD insertion and removal run the promotion of the IUD. A full range of other methods is offered at the clinic providing the women with access to many contraceptive options. The clinics also provide contraceptive counseling to accompany these methods. PSI/Myanmar gives IUD training to SQH clinic service providers and supports supervision to ensure that quality standards are followed. Their reproductive health day event provides this training and support and takes four days. The program started in 2003 and by 2007, it had trained 104 doctors in IUD use and a total of 11,570 IUDs had been inserted. Thus, using existing clinics and creating a social franchise has enabled PSI/Myanmar to expand IUD access, train service providers and ensure quality services for women. Reproductive Health training events jump-started the program and promoted the IUD. Program review meetings have confirmed a need to focus on IUD but have decided to reduce the team of doctors managing the event from 3 to 2 doctors and these will now share roles among themselves. However, community mobilization will still be done before the event. Although SQH clinic doctors can now provide services on their own, PSI will keep supporting them and plans to train more in the coming year.

**Paper 3: Total Market Approach to Improving Family Planning Access in the Republic of Georgia.**

**Presenter:** Nancy Harris for Nino Berdzuli, John Snow Inc. United States of America.

**Summary of Presentation**

The presenter introduced Georgia Republic as a breakaway state from the former Soviet Union. It is the second oldest Christian country in the world of 5 million people. Abortion is the most widely used method to regulate fertility. The presentation focused on the JSI-supported public-private partnership model to improve access and utilization of family planning services in Georgia. Since family planning is not part of the state-funded primary health care in Georgia, there is limited access to and use of modern family planning especially in the rural areas. JSI started work in Georgia aiming to reduce abortions and create demand for and access to modern family planning among underserved populations. JSI worked with stakeholders to obtain a waiver from the government to eliminate legal restrictions around the provision of family planning services for family doctors and nurses in rural primary health care clinics. Following the waiver, JSI worked with the government to develop family planning guidelines and a training curriculum. They collaboratively segmented the market and established the following three categories and an appropriate family planning distribution for each category: (a) The poor rural families got free US-Government donated contraceptives and the district public health authorities had the responsibility of monitoring distribution, (b) To ensure continuous supply of affordably priced contraceptives, JSI worked with private sector contraceptive manufacturers and distributors by signing agreements to produce low cost products and trained doctors and service providers to provide FP service and products at an affordable cost to couples who could afford to pay, (c) A social-marketing media campaign was launched under the slogan “Contraception-Modern Choice” involving the Ministry of Labor, Health and Social Affairs. For this campaign, information was distributed across the entire country through the use of radio and TV spots, billboards, IEC materials, and focus group discussions. The JSI intervention in Georgia has resulted in over 500 primary health care sites now offering modern family planning services which cover 60% of Georgia’s population. Evidence to-date suggests that abortion rates have fallen sharply following the intervention. The presenter summarized the factors for Georgia’s success as the following: (a) good logistics information management systems that minimized stock outs of FP products, (b) use of an evidence-based social marketing approach, (c) development of innovative public-private partnership focusing on rural areas with most need, and (d) the involvement and support of the government. The presenter concluded that developing trust and a common vision among the public and private sector not easy and that it requires long-term investment. However, this is difficult to balance against the needs of donors to have fast results. In the end, working with all stakeholders from top-to-bottom is an effective strategy and ensures wide coverage. The best programs are flexible to changes in the market and evolve over time.

**Paper 4: Experience of Oromia Development Association on Cost-Sharing.**

**Presenter:** Mulugeta Hawas, Oromia Development Association, Ethiopia
Summary of Presentation
The presenter introduced Oromia as the largest regional state of Ethiopia characterized by high maternal and child mortality rates, low contraceptive prevalence rate at 15%, and high unmet need for family planning, which is estimated at 41%. With support from Packard Foundation, Pathfinder, JSI and other partners, Oromia Development Association has implemented a community-based family planning program for the past nine years. The presenter described two key features/activities of the program. First of all, red uniform Community-Based Reproductive Health Agents (CBRHAs) trained and provided family planning services to over one million clients in eight zones and 2600 villages. The second main activity was the use of a variety of IEC to create awareness about the program and a service fee was charged as a form of cost sharing to help expand the services to underserved rural communities. The program is run and guided by the principle that; “Communities should pay for the services received at affordable prices but those who cannot afford shouldn’t be denied the services”. The presenter explained the reasons for cost-sharing, which include sustaining the availability of services supplies and incentivizing CBRHAs to enable them to continue providing services after the intervention comes to an end. The program design includes a revolving fund and some of the proceeds are used to purchase contraceptives to reduce dependency on donor funds. As part of implementation, community leaders are consulted to determine the price that the communities can afford to pay. Those who are poor and can’t afford to pay are referred to public health facilities for free family planning services. However, if they live too far away from the public health facility, family planning services are provided for free. Those individuals who are poor but have viable income generating project ideas are linked to micro-finance institutions that can provide them with microcredit loans. A simple and effective accounting system has been developed to manage the revolving fund where by 60% of the money collected is paid back to the CBRHAs and 40% is deposited in block account to use in procuring the contraceptives. An assessment carried out by the Ethiopian Ministry of Health found that in areas covered by the program more than 98% of clients are paying for the services they are receiving. This implies that these clients value the services. If CBRHAs remain motivated, the funds that are generated can be used to replenish stocks. This shows that the project is sustainable even after the donor funding is exhausted. The presenter concluded that advocacy for family planning service charges should continue to ensure contraceptive security efforts.

Discussion
Ethiopia: In the Ethiopia community-based family planning cost-sharing program in Oromia, how do people continue paying for the services in this era of global economic crisis? The presenter clarified that communities pay a nominal fee for the service and if they genuinely can’t afford this fee, the services are given free of charge.

As to whether the Ethiopian program provides services to prisoners, the presenter explained that the program is rurally-based and that the government takes care of other populations of special interest.

Another participant wanted to know how the money collected from the revolving fund was handled. In response, the presenter explained that there is a very organized accounting system whereby the amount collected depends on the specific contraceptive method provided. Of this charge, 60% goes to the Community Based Reproductive Health Agents (CBRHAs) and 40% is deposited back to the program.

How do government full-time Health workers coordinate with CBRHAs? The presenter explained that health facility workers link up with CBRHAs at village health posts during outreach but he appreciated that this link is still weak and requires further strengthening. As part of this effort, the WHO has agreed that with the support of trained health workers CBRHAs can provide Depo Provera (injectables) at the community level.

One participant wanted to know the reasons behind the current scenario in Ethiopia where a decrease in prices has not translated into a similar increase in family planning utilization. The presenter appreciated that there is a need for in-depth analysis of possible factors apart from service charge. Individuals who can’t afford to pay are referred to public health facilities for family planning services- is this a barrier?
Georgia: A participant wanted to know how the private insurance companies have been brought on board to cover family planning. The presenter responded that this has been possible because clients pay a small fee to motivate private service providers. In addition, this was negotiated between USAID and private insurance companies and the companies agreed to put family planning in their package services. As a result, the project trained health workers in the private sector about family planning.

What are the synergies between the market/private, public and social marketing segmentation? The presenter explained that we need to look at all sides with the view of reaching all people. For example, those who can afford to pay can access service from the private/market sector but for those who completely cannot afford should get free services while social marketing is cross cutting to provide highly subsidized/low cost (cost recovery) for continuity of the programs.

One participant wanted to know why the TFR is going up in Georgia at the same time that the CPR is increasing and abortion is decreasing. The presenter attributed this trend to the encouragement of couples to reduce the number of children that they have from 5 to 3 and the fact that FP is replacing abortions as a fertility control method.

Myanmar: One participant wanted to know the difference between the first and second round of training in Myanmar. The presenter explained that the first training was on site/clinics and at health events to train service providers while in the second round PSI/Myanmar team visits to support field based clinics, ensure quality assurance and confidence building.

Nigeria: A participant asked, “has there been a comprehensive research on the female condom in Nigeria as a whole?” The presenter explained that they have begun a fresh female condom program and are in their first year and hope to do a mid-way research in 2010 on female condom.

Key Recommendations

- Operations research should be a key component in FP/SRH program design to generate useful information for refining the approaches to improve uptake of FP and expand coverage.
- Innovative cost-recovery models like that in Omoria Ethiopia should be well documented and widely shared to provide guidance to new programs wishing to adopt such approaches in ensuring sustainable contraceptives for all.

SESSION D08: ADDRESSING THE FP NEEDS OF PEOPLE LIVING WITH HIV II

Moderator(s): Lilly Memory Banda-Maliro, USAID, Malawi; Alice Auma Olawo, Family Health International, Kenya

Presentations

Paper 1: Effect of hormonal contraceptive use on time-to-death in female incident HIV seroconverters in Rakai, Uganda
Presenter: Chelsea Bernhardt Polis, Johns Hopkins Bloomberg School of Public Health
Summary of Presentation
This study used data from a population-based cohort in Rakai, Uganda, to examine whether using hormonal contraception accelerated time to death among HIV-positive women. A previous randomized controlled trial suggested that HIV-positive women on oral contraception progress faster to AIDS or death than non-users of contraception. However, methodological concerns about the analysis prompted the present study. The data used for this study represent over 10 years of follow-up and include 625 incident seroconverters (4 years of follow up, on average). The authors used multivariate Cox regression with time-varying exposure information to assess the effect of hormonal contraception on time from HIV seroconversion to death. These findings indicate that time-varying exposure to hormonal contraception is not associated with increased hazard of death (HR=0.72, p=0.293). The authors also conducted a
number of sensitivity analyses, including using a lagged exposure in case women discontinued contraceptive use due to illness. Results from this sensitivity analysis did not suggest time-dependent confounding. These analyses indicate that neither oral contraceptives nor injectables are associated with increased mortality for HIV-positive women.

**Paper 2: Predictors of Pregnancy in Microbicide Trials**  
**Presenter: Vera Halpern, Family Health International**  
**Summary of Presentation**  
Women are excluded from HIV prevention trials involving investigational drugs if they become pregnant, and high pregnancy rates undermine interpretation of many expensive trials. Excluding women who become pregnant reduces the study’s power to detect an effect, or biases the findings toward the null. This study used longitudinal data from four microbicide trials to identify factors that increase women’s hazard of becoming pregnant during the study period. In total, 6,748 women participating in trials conducted between 2004 – 2007 in Nigeria, Ghana, Benin, Uganda and South Africa contributed data to this study. Using multivariate Cox regression, the authors examined factors associated with time to incident pregnancy among these women. The hazard of pregnancy was higher among women who were living with a man, had a previous pregnancy or were engaged in trade and commerce compared to other professions. The risk of pregnancy was lower among students, women using injectables or long-term contraceptive methods at baseline, women who used a condom at last intercourse and women with multiple sexual partners in the past three months. Though it might improve the efficacy of HIV prevention trials to exclude women with these characteristics, many women at high risk of HIV would be excluded. It may be more effective to improve contraceptive counseling during the trials for women at high risk of unintended pregnancy.

**Paper 3: Role of Menstruation in Contraceptive Choice Among HIV-Positive Women in Soweto, South Africa**  
**Presenter: Catherine S. Todd, Columbia University**  
**Summary of Presentation**  
High discontinuation rates of hormonal contraceptive methods have been documented among HIV-positive women, due to menstrual bleeding pattern disturbance. This qualitative study aimed to describe HIV-positive women’s perceptions toward menses and contraceptive-induced amenorrhea and to describe the impact of these perceptions on contraceptive choice and discontinuation. In total, 42 women aged between 16-45 years participated in the study, which included focus group discussions and in-depth interviews. Women perceived menstruation as a way for “dirty blood” to leave the body. They worried that if menstruation did not occur, they would suffer adverse health effects. As such, many women were psychologically comforted by regular menstrual cycles. Most women had not noticed any changes in their menstrual cycle after being diagnosed HIV-positive; however, some HIV-positive women indicated that seeing their menstrual blood reminded them of their illness and made them uneasy. Some users of injectable contraceptives had lighter periods or no periods at all, and this was cause for concern that they could be pregnant. Women indicated that menstrual disturbances play a large role in contraceptive choice and especially discontinuation. Better counseling is needed to explain the biology of menstruation, particularly in the context of HIV-infection.

**Paper 4: Peri-conception pre-exposure prophylaxis for sero-discordant couples who choose to conceive children in resource-limited settings**  
**Presenter: Lynn T. Matthews, Beth Israel Deaconess Medical Center; Boston, MA**  
**Summary of Presentation**  
As ARV therapy becomes more accessible, people living with HIV are more likely to desire children. This systematic literature review proposed a conceptual framework for using pre-exposure prophylaxis (PREP) in order to prevent infection of an HIV-negative partner during conception. The authors found that, in serodiscordant couples in which the woman was HIV-positive but the man was HIV-negative, home-based artificial insemination provided the best peri-conception risk reduction. However, when the man is HIV-positive and the woman is HIV-negative, limited intercourse with short-term ARV treatment remains the most viable option. However, there are many cases in which the infected partner does not yet meet eligibility criteria for ARV therapy. In this case, PREP may provide a solution for helping couples to meet
their fertility goals. PREP is controlled by the HIV-negative partner, who takes a short-course of ARV medications around the time of intercourse. Potential risks of peri-conception PREP are teratogenicity and future ARV resistance in the uninfected partner, should he/she become infected. This could be a particularly undesirable effect in settings where second and third-line treatment regimens are limited. Animal data suggest few adverse events, but ongoing clinical data may offer more information with respect to human use.

**Paper 5: Scaling Up Balanced Counseling Strategy Plus to Improve the Quality of Family Planning and HIV Counseling through Linking Counseling and Testing with Family Planning Services, Kenya and South Africa**

**Presenter: Mantshi Elizabeth Teffo-Menziwa, Population Council, South Africa**

**Summary of Presentation**

This presentation described the Balanced Counseling Strategy (BCS) in Kenya and South Africa, which is a client-friendly approach to counseling on family planning together with HIV and STI prevention. The authors aimed to evaluate the effectiveness of this model of integrating HIV prevention and testing in FP services against standard practices. The study evaluating the BCS was a randomized controlled trial in six intervention and six control sites. Outcomes were quality of family planning services, quality of HIV services and client risk behavior. The counseling strategy included an algorithm for family planning method choice and a supporting set of job aides, which were palm-sized cards describing contraceptive methods, as well as STI/HIV risk. The percentage of clients discussing their reproductive intentions with counselors improved from 24-48% in the intervention arm and decreased in the control arm. The percentage of clients discussing 4 or more contraceptive methods with the counselor also increased from 18-26% in the intervention arm while decreasing in the control arm. Last, the percentage of clients discussing STIs in counseling increased from 17-29% in the intervention arm while again decreasing in the control arm. Training counselors in the use of these job aides required minimal resources and only 1 – 1 ½ days of time.

**Discussion**

One audience member asked Chelsea Polis about why she controlled for breast-feeding as a confounder in her analysis of hormonal contraception and time to death. Is breast-feeding independently associated with disease progression or time to death? The presenter replied that the association between breastfeeding and time to death is unclear. One study suggested a positive effect, and others have suggested no effects.

An audience member asked for clarification on the PREP literature review. She asked how many days each month an uninfected person would need to take ARVs for peri-conception PREP. Is it only for the period of ovulation or longer? The presenter replied that the details are not yet well understood. Peri-conception PREP is still in an experimental stage, but it is likely the uninfected partner would take ARVs around the time of ovulation.

Audience members had several other questions for Chelsea Polis about the Rakai study. One person asked if the data were collected during ARV scale-up in Rakai and whether that could have affected the findings. Dr. Polis replied that only three years of follow-up time were during the period in which ARVs were available in Rakai. If you exclude women who were recruited during that time, it actually appears that hormonal contraception reduces the hazard of death.

Two audience members asked Dr. Polis about potential socio-economic differences between users and non-users of hormonal contraceptives and wondered if this could have confounded the findings in her study. The presenter replied that there were many differences between users and non-users, but she controlled for these characteristics in her analysis.

Another audience member asked Dr. Polis when the women in her study started using contraception – at the time of enrollment or during follow-up? The presenter replied that it could have been at either time, but contraceptive use was measured as a time-varying exposure.
Last, an audience member asked Dr. Polis whether she knew the causes of death for women in her study. The presenter replied that they were not able to determine whether all deaths were HIV-related, but 80% of deaths among HIV-positive persons in Rakai are HIV-related.

**Key Recommendations**

- Health providers need to comprehensively counsel HIV-positive women and those at high risk for HIV on family planning use. Counseling on side effects is particularly important.
- Evidence suggests that HIV-positive women can safely use hormonal contraception, and this information should be incorporated in reproductive health counseling for HIV-positive persons.
- Family planning services should be integrated with HIV and STI services in order to take advantage of otherwise missed opportunities for counseling.

**SESSION E08: CONTRACEPTIVE FAILURE, UNWANTED PREGNANCY AND EC**

*Sponsor:* Institut National d’Etude Demographiques

**NOTE:** These presentations occurred in an order different from the program**

**Presentations**

*Paper 1: Contraceptive difficulties in Africa: what role for emergency contraception?*

*Presenter:* Nathalie Bajos, Institut National de la Sante et de la Recherche Medicale, Paris, France

*Summary of Presentation*

This research focused on four countries in Africa: Ghana, Morocco, Senegal and Burkina Faso. In all places, there has been an increase in premarital sex. The research question of this presentation was: Can emergency contraception (EC) reduce unwanted pregnancies and unsafe abortion? The aim was to analyze the potential for EC use and move the discussion away from unmet need and towards contraceptive challenges and difficulties. The theoretical framework for the study involves the premise that contraceptive practices occur within the context of social patterns and relationships.

The study conducted in-depth interviews with 50 women, 25 men and 15 service providers. It also uses secondary data from the Demographic and Health Surveys in the aforementioned countries.

From this information, the presenter divided sexual relationships into several typologies. For example, in some couples sexual pleasure overrides procreation and the aim of sexual activity is simply enjoyment. In these couples contraception comes as a secondary consideration and does not largely factor into decisions about sex. Other typologies include unwanted sex, when sex is forced upon an individual and ignorance of the risks of sexuality. For each of these groups, the presenter discussed whether EC would be a viable option. She also showed that women move through categories at different stages in their lives and that one woman does not fit neatly into one category. Finally, the presenter discussed that the fear of side effects keeps many women from using EC.

In conclusion, the researcher stated that premarital sex is a reality that must be faced and that EC can be seen as part of the solution to reduce unwanted pregnancy. She argued that EC should be promoted along with condoms. Finally, she discussed a potential shift from a “family planning” movement to one of “sexual autonomy.”

*Paper 2: Entry into sexuality and access to contraception: Comparing Morocco and Senegal.***

*Presenter:* Agnes Adjamagbo, Institut de Recherche pour le Development, Marseille, France.

*Summary of Presentation*
In setting the context for this presentation, the presenter discussed sexual debut as a marker of adult life. However, the increasing age of marriage results in a growing gap between sexual debut and marriage. This results in an increase in the risk for unwanted pregnancy and abortion. This study used data from two countries with increases in the age at marriage.

In Morocco, there is a total fertility rate (TFR) of 2.5 and high contraceptive prevalence due to longstanding family planning policies. There has been a great deal of propaganda promoting 2 child families and there is denial that premarital sex exists. Furthermore, sexuality and motherhood outside of marriage is illegal and there is a gender-based double standard in this rule.

In Senegal, the TFR is 5.3 and contraceptive prevalence is low. There is no propaganda for small families and the youth are less restricted in their sexual behavior. Sexuality outside of marriage is accepted but a sexual double standard persists. Although childbearing outside of wedlock is a misconduct, it can be reversed if the couple marries.

This study used 150 in-depth interviews to gain a better understanding of these very different situations. In Morocco, non-penetrative sex to preserve virginity is common. Therefore, no contraception is used. However, accidents sometimes occur. In this context men are likely to experience their sexual debut with a sex worker. Wealthy women are more likely to have premarital sex than their less advantaged counterparts.

In Senegal, non-penetrative sex also occurs. However, penetrative sex also happens for fun and with multiple partners. Pregnancy can be used as a means of getting married. Men seem to have a fear of forced marriage through paternity and a fear of STI’s and are more likely to use condoms than in Morocco. Once married, women have less power than their husbands and hormonal contraception is rarely used until after the first birth. Covert use of contraception makes men suspicious of their wives having affairs.

In conclusion, women experience contraceptive difficulties where stigma regarding premarital sex exists. Women with social and financial resources are better able to separate themselves from social norms. There is a need to promote information regarding hormonal contraception and change norms regarding premarital sex in both countries.

**Paper 3: Gender relations and unintended pregnancies in Ouagadougou: are men a problem or a solution?**

**Presenter: Clementine Rossier, Institut National d'Etude Demographiques, France**

**Summary of Presentation**

The premise of this paper is that the need for family planning is higher in African cities than in rural areas. However, contraceptive prevalence in urban areas remains low despite the fact that women’s status is usually better. For example, in Ouagadougou, only 37% of all women use contraception.

The goal of this study was to understand the relationship between gender relations and emergency contraception in Ouagadougou. In terms of data, they conducted 77 in-depth interviews with men and women where at least one partner did not want a child. The women were divided into two groups- those who were in an egalitarian relationship and those who were not. They then looked at male domination, which can be different pre and post marriage. In the less egalitarian groups, the researchers found that abuse of women and decision-making power were the major ways that married men controlled women. In non-marital relationships the men were able to control women based on marriage. Men could feign interest in marriage and use that to manipulate women. In more egalitarian relationships decisions are made jointly, there is no abuse, and both people are interested in marriage.

These dynamics apply to family planning decision-making as well. In egalitarian relationships, the couple decides together or the wife decides alone about contraceptive use. In non-egalitarian relationships, the husband decides the method of contraception or flatly rejects it. In this context, women can resist and
assert themselves through the use of emergency contraception, covert contraception use and abstaining from sex.

Nearly all unintended pregnancies occur when men reject contraception. Emergency contraception can be a tool for resistance.

Paper 4: Provider’s perspectives on emergency contraception and opportunities for enhancing access in Ghana, Burkina Faso and Morocco.
Presenter: Susannah Mayhew, London School of Hygiene and Tropical Medicine, United Kingdom.

Summary of Presentation
In this study, interviews were done with health care providers in Ghana, Burkina Faso and Morocco to understand their perspectives on emergency contraception (EC). The interviewers asked questions regarding its mechanism of action, its access to patients, and contraceptive failure.

In terms of its mechanism of action, most providers understood that it was not abortive. A few providers did think that it was an abortifacient and still others seemed confused and gave contradictory statements. Overall, most providers did not understand how it worked. In Burkina Faso, there was some concern about it displacing methods of family planning for those who have infrequent sex. This was less of an issue in Ghana and was not expressed at all by providers in Morocco.

Most providers agreed that there should be access to EC but they varied on the degree to which it should be available. A few providers in Ghana thought that it should be available to all. In Burkina Faso, providers tended to be a bit more cautious, arguing that there should be access but not completely unrestrained. Some providers expressed that it should be available through pharmacies due to concerns about hormones. When a client asked for EC, they were often given the drug. However, few providers (except in Morocco) initiated its use.

In responding to contraceptive failure, most providers were sympathetic to their patients. However, contraceptive user failure was sometimes met with ridicule. Other providers were judgmental towards those who came into their clinics without having used any type of contraception.

Based on this data and their responses to EC, the presenter classified providers into four main categories:
1. Enthusiastic
2. Cautious and Qualified
3. Reluctant provision
4. Refusal to intervene

In conclusion, the knowledge and response to EC varied greatly among the providers interviewed in Ghana, Burkina Faso and Morocco. However, for the most part they expressed favorable attitudes towards its use. In terms of implications, the presenter had three.
1. Communication of risk of unprotected sex- access to EC must not eliminate this understanding of risk.
2. Demand creation for EC- providers should provide it pre-emptively.
3. Repositioning family planning in West Africa- move focus to condoms and EC.

Discussion
The discussion centered largely around cultural and religious barriers to contraception and specifically to emergency contraception. One audience member had been working on EC in Egypt and expressed her opinion that the recommendation to change norms around premarital sex in Morocco was implausible and inappropriate. The presenter responded that researchers need to talk about realities and continue talking about them in order to promote change. Another audience member expressed that he foresaw an uphill task in promoting EC based on the idea that adolescents may increase risk behaviors based on their belief that EC is sufficient for protection. Another person expressed her challenges in promoting EC in
Uganda due to religion and culture. However, the last speaker indicated that religion did not seem to influence the provider’s opinions in the study. Finally, someone questioned the need for EC as compared to using regular oral contraceptives. Since EC contains progestin and does not contain estrogen, the idea is that side effects from large doses are less than they would be for combined oral contraceptives.

**Key Recommendations**

**Paper 1**
- Use EC as part of a solution to reduce unwanted pregnancy.
- EC should be promoted with condoms
- Move away from discussions of family planning and towards sexual autonomy!

**Paper 2**
- Promote information regarding hormonal contraception
- Change norms regarding premarital sex

**Paper 3**
- Move towards gender equality and egalitarian relationships to decrease unintended pregnancy.
- Promote EC as a tool for resistance for women in inegalitarian relationships.

**Paper 4**
- Communicate risks of unprotected sex, even with EC.
- Get providers to preemptively promote EC.
- Reposition family planning in West Africa to include condoms and EC.

**SESSION F08: HARNESSING SOCIAL INSTITUTIONS TO SUPPORT FP**

*Moderator(s):* John Cleland, London School of Hygiene and Tropical Medicine, UK; Linda Cahaelen, USAID, USA

**Presentations**

**Paper 1: Engaging Muslim leaders in support of family planning in Tanzania**
*Presenter: Gregory Kamugisha, Futures Group Tanzania*

**Summary of Presentation**
Tanzania is a country with high fertility, and women marry and have children at a young age. The lack of women in higher education is the main cause of the high TFR, and 55% of maternal mortality in the country is avoidable. The research team consulted the National Muslims Council of Tanzania in an effort to gain support for family planning in a country that has a large Muslim population. The research team conducted a three-day workshop that addressed and attempted to clarify family planning and reproductive health issues among members of the Supreme Clerical Council of Muslims. It used videos of other African leaders affirming their commitment to family planning. The discussions were not always easy, and were sometimes emotional and difficult. At the end of the workshop, the research team asked the participants for an official statement of support for family planning. After the discussions, the participants needed time to consult the Quran and some wanted to consult with a decision committee. The group re-convened several months later and created an official statement of support for family planning, which the presenter noted as being grudging support. The workshop indicated that linking the Quran to the local and relevant environment was crucial. Also, showing the support that other religious and community leaders from other countries proved to be an asset. It was more effective to focus on the MCH benefits of family planning rather than the population benefits.

**Paper 2: Improved sexual behavior among young women: The LEEP Experience**
Presenter: Oghenefego Onome Isikwenu, Inspiro Communications and Media Nigeria

Summary of Presentation
The LEEP program was designed for young women in school in Nigeria with the aim of empowering them economically and educationally. Since women get married younger due to poverty, more women are not being educated, and the program aimed to empower women to make their own decisions in their lives. The program worked with young women after school to improve their social skills and provide them with human rights education and vocational training, which included internet training. The program was later scaled-up to include young people out of school, widows, and married women. During the program, some women were able to start their own businesses. Participants had workbooks to work on with family and friends, with the aim to spread knowledge beyond the participant group. The project showed an increase in knowledge gained, especially from life skills, and many participants made a commitment to delay sex until marriage. Also, young women often did not have information on family planning, and speaking with community leaders helped advocate for support of the program. The presenter commented that the program caused an increase in participants’ knowledge and self-sufficiency, which allows them to make major changes in their lives and help achieve the MDGs.

Paper 3: Family planning, abortion and HIV in Ghanaian print media: A content analysis of the most widely circulated Ghanaian newspaper since 1950- The Daily Graphic
Presenter: Amos Laar, University of Ghana School of Public Health

Summary of Presentation
Ghana’s press is pivotal in politics, and became crucial in promoting national unity and democracy. However, the press largely neglects health issues in favor of sports and politics. The study aimed to determine if the press gives ample attention to family planning, abortion, and HIV. There are over 40 newspapers published in Ghana, but the Daily Graphic is the most widely circulated, so the focus was on this newspaper. The presenter used the composite week sampling technique and manually analyzed editions from January 2008- March 2009 for articles on reproductive health issues. The articles were analyzed based on headline size, column space, page placement, and picture enhancement. Results showed that coverage of reproductive health issues were poor, and the articles were not enhanced with pictures. .5% of total newspaper items were related to reproductive health. The presenter recommends that the newspaper staff be sensitized to reproductive health issues, and to encourage reproductive health activists to contribute to newspapers.

Paper 4: Assessing quality of family planning service provision among private patent medicine vendors in Nigeria
Presenter: Chinazo Ujuju, Society for Family Health Nigeria

Summary of Presentation
Most contraception in Nigeria is purchased from the medical sector, but most private distributors do not have a medical background. 10,000 private patent medicine vendors (PPMVs) were trained in providing family planning supplies, which increased sales of oral contraceptive pills. People prefer PPMVs to health clinics because they perceive them to be more convenient and less expensive. The aim of the project was to determine if the training in family planning dispensing skills, including counseling and referrals of complications to higher medical care was sufficient. Mystery client surveys were utilized to assess contraceptive dispensing skills of PPMVs, in addition to 8 in-depth interviews. About half of PPMVs referred clients who show complications to higher medical care, less than half of PPMVs referred new clients who needed family planning to higher medical care, and most of PPMVs had oral contraceptive pills in stock. This assessment shows a greater need for PPMV training.

Discussion
The audience asked the first presenter if the Muslim leaders promoted any method in particular, and about methods of dissemination of their support for family planning. The presenter responded that the leaders support any method that is legal and medically safe. The presenter also agreed that dissemination is very important, and that people need to know about it. He commented that dissemination through USAID has not yet happened, but the Muslim leaders are expected to transfer information. Once a policy is made, that will be the best method of dissemination.
The audience commented that in the second presentation, there was no baseline data, so how could improvements be measured? The presenter responded that the program had endorsed a commitment to abstinence, and the purpose of the program was to provide financial stability so that sexual behavior would decrease. The program followed-up with the participants and found that before the program, the participants engaged in risky sexual behavior.

For the third presentation, the audience inquired about the presenter’s choice of including only one, government-sponsored newspaper as the data for the study, and questioned the presenter about the conclusion that stories without pictures and that are not on the first page are not important. The presenter responded that the selection of the newspaper was based on two terms: coverage and impact. The Daily Graphic is the newspaper with the greatest number of people affected by it, and it covers all of Ghana. In terms of the measure of quality, the presenter commented that the measure was not only based on an absence of pictures, but also on the amount of space covered by the article. An audience member asked about the possible inclusion of press briefings for reproductive health events in the newspaper, and the presenter responded that the low coverage could be due in part to the period of time that was studied; perhaps there were no reproductive health events at this time.

An audience member expressed concern about the apparent low use of health centers in favor of PPMVs. The presenter explained that because the PPMVs had no medical background, they are not encouraged to initiate family planning, and that clients should go to health centers at least for contraceptive initiation. The presenter also explained the improved qualifications of PPMVs that arose from training, such as the PPMVs thoroughly explaining the side effects of contraception in order to encourage continuous use.

Key Recommendations

At the community level, the emphasis on MCH as a benefit of family planning is more effective than population-level benefits. Given that the media has a tremendous influence on public opinion, efforts should be made to sensitize members of the media on issues of family planning and reproductive health. Comprehensive training of all family planning service providers is necessary, but may not be sufficient in ensuring satisfactory family planning services.

SESSION G08: EFFECTIVE PROGRAMMING AND SERVICE DELIVERY III

Moderator(s): Susan Krenn, Center for Communication Programs, Johns Hopkins University, USA; Beatrice Atieno Ocheng, Family Health International, Kenya

Presentations

Paper 1: National Family Planning campaign in Mali: Repositioning the contribution of Family Planning
Presenter: Abdourhamane Maiga, Pragramme Sante USAID/ATN Plus, Mali

Summary of Presentation
The presenter explained that the rationale for the campaign was to provide advocacy for Family Planning at all levels; harmonize Family Planning messages; seek for leadership commitment at all levels; improve understanding of Family Planning; and mobilize financing for Family Planning from partners. The campaign themes include: improving birth spacing; challenges in Family Planning (the role of male); and high – level leadership commitment to re – enforce Family Planning. Key activities for the campaign were provided through: Radio and Television; print media; advocacy meetings and ensuring contraceptive availability. The following were the opportunities the campaign found: formation of a multisectoral Family Planning at national, regional, and district level (coordination); updated RH policy, procedures with ministry of health; training of providers (interpersonal communication, contraceptive technology); development of a communication strategy by USAID and UNFPA. The campaign resulted into a donation
of 18 million euros from the Dutch government (more investment); involvement of young people and the youth; decentralization of Family Planning programs; engagement of governments and civil society organizations; and follow-up of service providers in contraceptive technology; increased knowledge of Family Planning (Demographic and Health Survey).

**Paper 2: Family Planning Implementation Teams: Building Sustainable Community Ownership in Rural Uganda**

**Presenter:** Ms. Beatrice Byonomugisha, Minnesota International Health Volunteers, Uganda

**Summary of Presentation**

The presenter explained that a qualitative approach was employed to assess the contribution of community health workers to a sustainable family planning programs. It was a case study. Key informants were interviewed and observations were made during quarterly review meetings of community health workers. Content analysis of the themes was performed. The results of the community projects revealed sustainability and improved community ownership of the family planning programs. This called for follow-up of the following recommendations: balanced memberships for the community health workers (long and short-served members), regular meetings and multisectoral teams.

**Paper 3: The Confiance Family Planning Network: using a social marketing network to re-establish Family Planning in a Post-Conflict DRC**

**Presenter:** Mr. Jamaica Corker, Population Services International, United States of America

**Summary of Presentation**

The study investigated a franchising approach to increasing access to and use of modern family planning methods by promoting family planning information, services and products using a network of public clinics and pharmacies in Democratic Republic of the Congo. The results revealed an increase in couple years of protection from 37,156 in 2005 to 85,868 in 2009, which demonstrates an increased demand in sales. The presenter recommended continuation of the urban focus, provision of more products, and continued training.

**Paper 4: Policy Imperatives for Systems Oriented Approaches to Scaling Up: Case Example of Taking a New Family Planning Method to National Scale**

**Presenter:** Ms. Susan Igras, Institute for Reproductive Health/George Town University, United States of America

**Summary of Presentation**

The presenter explained that scaling up is not simply introducing a new service and training service providers. It also includes sustaining these services and strengthening systems. Findings from the scale-up of Standard Day Method (SDM) revealed that the need for system integration, political and technical support and service integration.

**Paper 5: Effect of integrating Family Planning Programmes**

**Presenter:** Dr. Khali Tawhinda, Johns Hopkins University School of Public Health, Egypt

**Summary of Presentation**

The presenter explained the contribution of communication programs to improving maternal and child health. Households can be seen as the producers of health. The project targeted young couples (below 30 years) utilizing antenatal care, delivery, postnatal care and birth spacing services. The Egyptian Ministry of Health, the private sector and NGOs were involved in the program. Information and services were delivered through television, radio and print, outreach and service support (protocols, guidelines and standards). The results revealed that there was an increased attendance for antenatal care (4th visit), increased assisted deliveries, and increased up-take of family planning services after the first child was born. Post intervention, 86% of couples reported ever used maternal and child health services and birth spacing increased by 33 months. The intervention also increased 4th antenatal care visits and safe delivery at the community level. The presenter concluded that communication influences RH service utilization.

**Discussion**
Responding to the concern of collaboration between Population Services International and faith-based organizations, the presenter explained that some of their partners are faith-based such as organization of women preachers. The Koran does not discourage family planning. Sustainability of community health program should be voluntary, community health workers should be recruited by the community while coordinating with the community through outreach.

**Key Recommendations**

- Scaling of interventions should be made simpler rather than complex.
- Family Planning is a social not a medical issue, hence it is important to create demand for it.

**18 NOVEMBER 2009 – PLENARY**

Not recorded.

**18 NOVEMBER 2009 – CONCURRENT SESSIONS**

**SESSION A09: MOBILIZING COMMITMENT AND FUNDING FOR FP**

*Moderator(s):* Pape A. Gaye, IntraHealth, USA

**Presentations**

**Paper 1: The Fall and Rise of the Green Star: An Analysis of the Effects of Program Restructuring to the Weakening of the Tanzania National Family Planning Program and Advocacy Efforts to Revive it.**

*Presenter: Christine Lasway,* Family Health International

**Summary of Presentation**

In Tanzania, the MMR and TFR have not fallen in the past decade, despite progress during the "golden age" of family planning services during the 1990s. This progress was attributed to top level national leadership, a well-funded, centrally managed vertical national program, a strong communications campaign, active engagement of NGOs, and a strong national community based distribution program. The presenter described the current status of the family planning program as the “falling green star”, since the green star is the symbol of the FP program. Currently, there is less visibility of FP in the national development agenda, but demand for FP is still rising. This has led to an impetus to reposition FP in Tanzania, an effort that involves advocacy, the establishment of a national FP working group, a service delivery guidelines update, and nationwide training efforts. Implementation of such a project is estimated to cost $120 million over 5 years, most of which is planned for contraceptive commodities. Expected challenges to implementation include the fact that FP competes with other priorities, that FP uptake is not a performance indicator for decentralized council health plans, the lack of human resources, and an over-reliance on short-acting methods.

**Paper 2: Engaging the Poor on Family Planning as a Poverty-Reduction Strategy**

*Presenter: Anita Bhuyan,* Futures Group International

**Summary of Presentation**

The author described the EQUITY approach to FP/RH access, which focuses primarily on the first component of this approach: engaging and empowering the poor. This is crucial to narrowing the gap between rich and poor, which is growing despite poverty-reduction strategies in many countries. Addressing population growth in poverty reduction efforts is important given that the poor often have larger families, more early pregnancy, shorter birth intervals, and high unmet need for FP. All of these issues have health, education and economic implications. The presenter provided specific examples of
how the poor have been engaged in policy and planning. The presenter concludes that efforts to engage the poor are useful, and result in policies that are better suited to the needs of the poor. They also offer the potential for more ownership of these processes by the poor and result in more sustainability.

**Paper 3: Use of the RAPID Model for Advocacy with High-level Decision Makers**  
**Presenter:** Thomas Goliber, Futures Group International  
**Summary of Presentation**  
How do we mobilize political will and leadership for provision of quality FP, as called for in Maputo? The fundamental arguments for family planning can be classified in three broad categories: human rights, health, population and development. The last category is broken into the following four parts: (i) demographic benefits, (ii) human capital development, (iii) economic development and (iv) poverty alleviation, environment and agriculture. There has been a renewed interest in Africa in the “population and development” argument, but all three arguments remain useful and valid. Advocates must choose the appropriate one for the political setting in which they are working.

**Paper 4: Global Resources Required for Family Planning Programs in low- and middle-income countries**  
**Presenter:** John Stover, Futures Institute  
**Summary of Presentation**  
No recent estimates of the global financing requirements for family planning have been produced. This study sought to fill the crucial gap in the evidence base by asking the question: what financial resources will be required in the future to support FP programs in low and middle-income countries? The investigator collected updated costs of service delivery in four countries, projecting number of FP users by method, and adding program support costs such as policy and advocacy, evaluation, logistics, communications, research, and training. Barriers to success include stock-outs, lack of funding, lack of trained staff, poor provider attitudes, lack of rural access, rumors and misconceptions, and discontinuation. The presenter showed total estimates of costs of FP services to meet need, broken down by payer (out of pocket, donor NGO, national governments, donor support, and donor commodities). Costs are largely paid for out of pocket and by national governments.

**Discussion**

An IPPF representative expressed frustration regarding the fact that the promise of the Tanzanian government to allocate 9.2 billion to FP for 2009 and 2010 is now being retracted by the Permanent Secretary, and asked who is responsible. Christine Lasway responded that while this is the million-dollar question, the Ministry of Health and JSI have a contraceptive security working-group looking into these issues on a continuous basis. Discussion ensued regarding the expense allocations presented, and that only 2% was provided for capacity building and health systems strengthening. Audience members were concerned about the concentration on the supply side at the expense of the demand side, noting that with the young population structure in Tanzania, information on RH and FP is paramount. Christine Lasway responded that there are ongoing efforts to coordinate youth activities.

Another audience member asked Thomas Goliber whether we are moving to a new paradigm shift in the way we promote FP, similarly to the way our paradigm changed after ICPD. Thomas responded that the ICPD paradigm is alive and well, and that no major shift is occurring. However, he noted the renewed interest in the population growth factor, particularly in sub-Saharan Africa.

**Key Recommendations**

- The Tanzanian experience highlights the fact that positioning FP is not a one-time effort, and we must remain engaged in collaborative action to maintain success. Understanding cost implications can help frame advocacy efforts.
- Efforts to engage the poor on FP as a poverty-reduction strategy are useful and result in more realistic and sustainable policies.
There remain three fundamental arguments for family planning: human rights, health, population and development. Each are valid and should be appropriately utilized according to political contexts.

Updated cost projections for FP programs are needed to sustain government and donor support in the context of other emerging health and development priorities.

SESSION B09: LEADING AND MANAGING RESULTS FOR RESULTS IN FAMILY PLANNING

Moderator(s): Timothy R. Allen, Management Sciences for Health, USA

Presentations

Paper 1: Makerere University’s Investment in Pre-Service Action-Oriented Leadership and Management Training: What are the Lessons for Family Planning?

Presenters: Morsi Mansour and Stephen Kijjambu, Management Sciences for Health (MSH)

Summary of Presentation

One of the presenters began by giving an experience of medical students who leave university after graduating and they are told to manage a health facility, district or even manage a regional referral hospital. With poor leadership and management, the health care system continues to dwindle in provision of quality health care services. Such a background set precedent for the COBES project at Makerere School of Medicine. The presenter mentioned that each medical student was to spend at least 2 months a year working at a community health site. This, he said, was geared at equipping students with knowledge, skills and attitudes to face the leadership and management challenges after medical school. According to the second presenter, there was an increment within 6 months in the number of deliveries in Ndejje Health Centre of 35% and at St. Stephen’s Rural Hospital at an average of 4 deliveries per month due to the project intervention. Findings show that investment in pre-service leadership and management programs and training improves on health outcomes. Equipping students with good leadership and management skills empowers them to work with other health workers and improve the wellbeing of communities they serve.

Paper 2: Improving Leadership and Management at the Front Line to Scale-Up and Accelerate Family Planning Results

Presenters: Joan Bragar Mansour, Management Sciences for Health (MSH)

Summary of Presentation

The first presenter said that Leadership Management Program managed by MSH was geared towards improving the leadership capacity of providers of FP/RH services. It is on this basis that ACQUIRE Tanzania project wanted to explore the value-added of integrating the LDP in the family planning services to address the service delivery challenges. The trainers used a challenge model pathway to build ownership of performance improvement, which helps increase provider commitment and motivation to achieve results. The second presenter noted that the selected teams explored their FP data reviewing the low uptake of the services and made priority action plans for their health facilities. Findings of the project present an increment in the clients accessing FP/RH services at the piloted health facilities. In addition, the service providers were motivated, committed and had improved skills for delivering services. The training was replicated with local leaders in Kigoma, district officials and other service providers. As a result, motivation from the trained service providers they scaled up to other dispensaries and health facilities Kigoma. The presenter recommended the involvement of the community, which contributes to sustainability of programs, continued support supervisions and ownership of improving the services by health providers increases the uptake of FP/RH services.

Paper 3: Developing a framework and Approach for Measuring Success in Repositioning Family Planning

Presenter: R. Scott Moreland, Futures Group, United States of America
**Summary of Presentation**
The presenter explained the term reposition family planning, which means renewed efforts to ensure that FP remains a priority in an environment of high levels of funding for other global health programs such as HIV/AIDS and malaria. With efforts made by different affected countries bridging the gap, the ability of countries to assess the success of their efforts to reposition FP still remain futile. Therefore, they set out to develop a framework by which countries and programs could monitor and evaluate their progress on FP repositioning. The study, which was based on information from different key informant interviews and different stakeholders, explores family planning programs and project activities, inputs and outputs as well as impacts on a program. Although it is still being developed, the framework will be used by target beneficiaries who may include international donors, governments and programs to assess their efforts in repositioning Family planning. The information gained from the use of the framework and M&E approach can be used for program design, advocacy, funding and policy implementation.

**Paper 4: Scaling up Proven Public Health Intervention through a locally Owned and Sustained Leadership Development Program in Rural Upper Egypt**

**Presenter: Abdo Hasan El Swesy; Ministry of Health and Population, Egypt**

**Summary of Presentation**
The leadership development program was aimed at improving health services in Aswan governorate by increasing managers’ ability to create high performance results. After three years of the leadership development program training, USAID funding stopped which impacted the training. With support from MOHP, the trained local nurses and doctors scaled up the program to other health units in the country. The presenter commended outputs of the program that had significant results on different health indicators in the community served. Findings show reductions in maternal and infant mortality, an increase in the number of clients seen, infant care and average ANC visits. The Ministry further incorporated the LDP in the pre-service training curriculum for physicians. The lessons learned in the program were that health providers can make great improvement in health care provision through their commitment, management and leadership skills gained. It was also noted that even with the cessation of donor funding, once there is a will and shared vision among health providers they can improve the health of communities they serve.

**Discussion**
One of the participants commended the presenters especially the one from MEASURE Evaluation. She was glad that a framework was being developed to monitor and evaluate FP programs. The paper on Egypt’s LDP program raised a number of questions from the audience. Questions were asked about the model and why they people would attribute their successes to the programs or framework. He was also asked how they managed without donor funding, and how much of their successes could be attributed to the support from the donor funding. The presenter mentioned that what motivated people to change was the fact they were included in all the discussion, meetings and action plans for the health facilities. Results at the health facilities motivated the health care providers who were excited about the health indicators. In addition there was demand created at service centers, as there was an increment in new clients at the units. When funding stopped local facilitators agreed to replicate the program to other districts in Egypt based on observed benefits of the program. According to the presenters, the leadership and Management program will help improve on the well being of many community members as long as the health care providers are committed, and own the program.

**Key Recommendations**
- Pre-service leadership and management development can help scale up proven public health practices, including family planning and other interventions to achieve the MDGs.
- Training curriculum for health providers should include components of leadership, management to empower them with managerial and leadership skills in order to scale up proven practices and improve on the health of the communities they serve.
• Empowering managers, refresher training and community involvement in ownership of programs would help sustain introduced practices even without donor funding as demonstrated by the health facilities.
• Support supervision and replication of best practices to other Facility teams and units would help improve on the unmet need and scale down morbidity situations
• MEASURE Evaluation model/framework will be an ideal model to be used in monitoring and evaluation the family planning programs. This framework should be improved and availed to implementing partners hence reduce on the problem high population growth.

SESSION C09: ACCESS TO RH ESSENTIAL MEDICINES AND COMMODITIES: THE MISSING LINK TO IMPROVING RH.

Moderator(s): Maggie Usher-Patel; World Health Organization, Switzerland

Presentations

Presenter: Elizabeth Westley, International Consortium for Emergency Contraception, United States of America
Summary of Presentation
Following the launch of the multi-pronged strategy to expand access to EC, a strategic introduction was undertaken in selected countries. The results of the consortium were mixed and the introduction took a little bit longer. Several achievements were registered for instance; EC is now available in over 140 countries and also available over the counter or direct from pharmacies in over 40 countries. The major challenges are that EC is not included in the Public sector supply chain in most African countries, it is fit for pharmacy access and tends to be expensive, pharmacies and drug shop access increases challenge of bridging from EC to regular contraception. It is also important to note that EC is being abused by the youth and in most cases has limited donor support. The consortium also noted new issues like counterfeit and poor quality drugs, politics and the media being more important than anticipated. The presenter concluded with the key messages from the consortium, which included; Registration and access issues being more challenging than expected and emerging challenge of counterfeit drugs among others.

Paper 2: Policy and Advocacy Initiatives for Reproductive Health Commodity Security
Presenter: Jotham Musinguzi, Partners in Population and Development Africa Regional Office, Uganda.
Summary of Presentation
The presenter noted that RH commodity security existed when everyone had the ability to choose, obtain and use RH products whenever they needed them. He argued that advocacy aimed at policy-makers, RH networks and communities coupled with a strong supply chain would ensure availability and access to RH commodities. In Uganda, he noted that the Partners in Population and Development Africa Regional office and other civil society organizations had taken initiative in this area through the use of comprehensive frameworks for commodity security, policy frameworks on integration of FP and HIV/AIDS and increasing funding at various levels among others. Primary targets for advocacy efforts included parliamentarians, women RH groups, faith-based organizations, community-based organizations, cultural institutions and the media. The major challenges on the other hand are non-commitment of political leaders to RH issues and lack of funding for meaningful advocacy.

Presenter: Leslie Patykewich, USAID, Deliver Project
Summary of Presentation
The presenter highlighted the growth in number of products and family planning clients in many countries and the resulting need for expanding warehousing, information management and staff to manage these
functions. As a result, the private for profit commercial sector has evolved to create new programs such as public private partnerships (PPP) and third party logistics (3PLs) to whom they outsource specific functions. The advantage with this is that Ministry of Health can focus on what they can do best, improved performance and cost reduction. In outsourcing, it is important to consider the different skills, mutual trust and the trade offs. Internal assessment and the feasibility of outsourcing should also be evaluated. It is important to note that outsourcing does not guarantee success. The presenter also noted that outsourcing has its challenges, which included duplication, loss of control and political consequences. Some of the lessons they learned were that finding a selection of reputable 3PL with adequate capacity was a challenge, clear performance measures are critical and that the policy environment should be conducive to foster PPPs. Generally, outsourcing has a potential to improve performance and it is critical to consider it on a case-by-case basis.


**Presenter: Ahmed Kabir**, Technical division UNFPA/NY

**Summary of Presentation**

The purpose of this collaborative initiative was to present a “snapshot” of the current status of access medicines for maternal and newborn health care and reproductive health which are not routinely monitored. The six RH medicines chosen were Oxytocin injection, Ergometrine injection, Magnesium Sulphate injection, Ampicillin injection, Gentamicin injection and Metronidazole injection. The findings show that they were mostly available, but incidences of stock-outs/ or overstocks existed and there were discrepancies between availability and usage. Some of the RH medicines were not in the essential medicine list but were available in the country. The costs had a wide variation, as there was a lack in price control. Generally, the findings from this assessment created strong awareness among governments, policy makers and key stakeholders. Key actions in terms of immediate, midterm and long term interventions required have been suggested and well received by the governments and other partners.

**Discussion**

Many countries needed to get Oxytocin on their essential drug list and also consider it on their national funding. The presenter from Bangladesh also noted that PPP and EC were a success in the country.

**SESSION D09: PROMOTING ACCESS AND AFFORDABILITY OF FP**

**Moderator(s):** Angela Akol, Family Health International, Uganda

**Presentations**

**Paper 1: What Type of Programs have been Successful in Increasing Access of Marginalized Groups to FP/SRH?**

**Presenter: Nuriye Ortayli**, UNFPA, United Stated of America

**Summary of Presentation**

The presentation focused on how to reach disadvantaged groups, particularly those currently facing high unmet need. The presenter noted that Contraceptive Prevalence (CPR) rates differ across countries and among different groups. The CPR measures inequality and quality of services in terms of behaviors. Since family planning services are taken up on a voluntary basis to delay or avoid pregnancy, the unmet need for family planning is the number of couples who do not want another child in the next year but are not using family planning. Africa has the lowest access to family planning services and products while Latin America has the worst social-economic factors, resulting in low FP utilization. The presenter mentioned the following factors for low utilization and possible remedies as follows:

1. In rural settings of many countries use of FP is limited thus program managers need to address these gaps
(ii) Age is another factor—young people are disadvantaged to use FP therefore specific interventions are needed to reach this group. When programs target the entire population without targeting special groups such as the youth and rural populations, inequalities can arise.

(iii) The use of “averages” in measuring impact such as in FP utilization and MDG progress does not adequately tell the picture of those groups who are left behind. In short, national averages hide inequalities. Thus suggested a need to use targeted approaches to address inequalities especially in Sub-Saharan Africa.

The presenter noted that although some progress has been made, this always applies to urban populations continue to have the easiest access to RH services and rural based populations are exposed to most risks. A failure to target rural populations increases morbidity and mortality rates.

The presenter noted that UNFPA, WHO and others have developed tools to determine who the missing populations are, where they live, what they do, and what they think. Using this information, they can develop and implement appropriate approaches to reach them. The presenter noted that in order for interventions to reach these challenging populations, they should apply an intersectoral approach. Furthermore, the approach should be participatory in nature and involve disadvantaged groups. In this way, they will be able to articulate their problems and feel involved in the process. The decision to provide services at a fee should be carefully determined based on the context. There is also a need for direct targeting and building of Primary Health Care (PHC) to provide essential services. In some cases, there is need to re-examine access to PHC at rural centers to see if there are gaps. If gaps exist, it is strongly recommended that they consider the use of alternative approaches such as community-based distribution (CBD), lady health workers, and outreach services. One should assess these tested models and modify them to suit the context.

Paper 2: Integrating Equity Goals and Approaches into Policies, Plans and Agendas.
Presenter: Suneeta Sherma, Futures Group International, United States of America.

Summary of Presentation
The presenter emphasized that to reach the poor, there is need to integrate equity goals in population policies and link family planning to national development goals. This helps to increase resource allocation to sexual and reproductive health interventions to reach the poor. Policies show where the gap is and what resources are needed to reach the desired outcome. Although most policies acknowledge that reaching the poor is hard, rarely do they adopt a comprehensive approach to address the barriers that inhibit their access to programs. At the policy formulation and resource allocation levels, the poor don’t have strong advocates for their interests and therefore services never reach them. This calls for equity analysis during policy formulation to ensure that governments prioritize the needs of the poor in designing national programs. All stakeholders should be involved especially Civil Society Organizations at the community level, and relevant ministries and departments. There is a need to design effective Monitoring and Evaluation systems with clear indicators to track how the plan to reach the poor is progressing. In terms of resource allocation, accountability, target groups and persons responsible to deliver the services should be clearly articulated. The presenter mentioned that the push for equity goals in designing national development agenda has already been progressing. For example, in Kenya all stakeholders were involved in ensuring that equity goals are considered in designing appropriate national FP/SRH Strategy that has enabled improved resource allocation by the government. In India, a policy assessment tool was applied to determine gaps and information and used to design long-term goal and appropriate population policy and strategy. This strategy has reduced barriers to access. To achieve equity goals for family planning and SRH, different models have been used in India such as mobile programs, outreach, voucher schemes, and allocation of resources based on levels of poverty/income. In the case of Mali, the link between addressing the unmet need for family planning and achieving MDGs has been greatly appreciated and family planning was included in the poverty reduction strategy. In Rwanda, there is presidential level commitment to address rapid population growth. This is a big step towards achieving the 2020 Rwanda National Development Plan. The presenter concluded that equity is important and one must involve the poor, understand barriers, and re-allocate resources. Finally, all sectors, public and private, have a role to play.

Presenter: Anthony Mbonye, Uganda Ministry of Health.
Summary of Presentation
The presenter noted that policy change in relation to innovative health service delivery, such as community-based provision of DMPA, is always challenging. In 2003, the Uganda Ministry of Health agreed to conduct a pilot test for DMPA at the community level. The rationale was to increase community-based access to injectables as another form of FP method. The reason for expansion of community-based injectables is that the pilot has provided evidence that it is an effective, safe and feasible service for underserved population and can help fill in the apparent gap of trained health workers facing Sub-Saharan Africa. It increases CPR especially in rural communities and is in line with the WHO task-shifting framework. The presenter noted that the MDGs cannot be met unless family planning and SRH are addressed because it is critical to reducing child and maternal mortality. In June 2009, technical experts met in Geneva and were in agreement that community-based injectables can drastically increase access at the community level. Based upon Uganda’s successful pilot of injectables at the community level, other countries have embarked on scale up of this intervention. Using the lessons learned from the pilot, Uganda has embarked on targeted scale up of the program in seven additional districts. NGOs have incorporated injectables into their work plans but Uganda is yet to make the required policy changes. Countries implementing community-based injectables programs include Madagascar, Malawi and others. In the case of Madagascar, as part of strengthening FP services the Ministry of Health in 2006 agreed to include DPMA as part of the services to be offered at the community level. The national reproductive health norms were consequently updated to set standards for quality. Family Health International (FHI) and PSI pilot-tested the program in two regions. In the case of Malawi, as part of revitalizing family planning, in 2008 the government changed the policy to allow health surveillance assistants to administer DMPA. As compared to the above two cases, the presenter noted that the key challenges for Uganda have been the lack of new policy framework to support community-based DMPA and resistance from medical professionals. The issues raised by medical professionals include safety concerns and adding a burden to the already overstretched community health workers. In conclusion, open communication among all stakeholders is critical in identifying obstacles and devising solutions to increase family planning access.

Presenter: Nancy McGirr, Futures Group, United States of America.
Summary of Presentation
The presenter started by noting that barriers to access and utilization of FP/SRHS among the poor are a valid problem. She introduced two concepts of demand and supply to illustrate that the poor lack both when it comes to FP services. In many cases they can’t afford the cost, services are not provided in a timely manner, there is poor male involvement and support and/or policy does not adequately address barriers to access. Several factors that inhibit the poor from accessing FP services such as lack of information about the services, inaccessibility to health services, indirect costs to services such as transport cost and user fees, and laboratory costs which add up to make the services expensive. The presenter mentioned innovative strategies to make services affordable and available to the poor. These strategies include contracting out services to the private sector at subsidized prices, voucher mechanisms, cash transfer mechanisms and Behavior Change Communication (BCC) to provide the required information to influence decisions and practice. The presenter highlighted the challenges that need to be tackled. These include limited access to health services, low male involvement, limited knowledge of the use of contraceptives and lack of trained health providers. The presenter observed that opportunities that should be utilized include national program goals and commitment to national and international targets. These goals already support institution delivery. Furthermore, the vibrant private sector is already offering quality health services and can be motivated to take up FP/SRH services. In a case study in India, the presenter indicated that a voucher scheme has increased access to and utilization of FP services among the poor. This intervention covers a total of 199 villages with a comprehensive package of ANC, FP, and postnatal services. Under the scheme, prices are prior negotiated to affordable levels. The voucher management system involves the district health department and other key stakeholders. The households, individual women in need, nursing homes, service providers and community health workers are able to run the program. As a result, 7 private health facilities have been accredited and 472 health providers have been trained thereby greatly increasing access to the poor. The presenter showed that targets especially for ANC, institutional delivery and PNC have been
met and that clients are extremely satisfied with the services particularly family planning. The quality of the program conforms to the standards. Finally, the presenter concluded that using the voucher scheme can be an effective way to offer quality services at reduced prices and thus reduce pressure on government health facilities. The program is expanding to six more districts and will reach another 4 million people in India.

Discussion

Uganda: Responding to the question about criteria followed in Uganda to allocate resources for FP/SRH service, the presenter explained that size of the population in a given area is a key factor used in allocating PHC funds but other factors are considered.

When asked about Uganda’s strategy for scale up of community-based Depo Provera, the presenter explained that after a successful pilot in Nakasongola District, the program has been scaled up to 7 more districts to continue documenting evidence for use in lobbying the policy makers and medical practitioners to put in place a suitable policy framework. The presenter clarified that they intend to arrange for district officials themselves to share their experiences about community-based Depo Provera with policy makers to quicken policy formulation.

One Ugandan Member of Parliament attending the conference expressed that policy makers are willing to change FP policy but require explanation of the diverse effects of Depo Provera on the population particularly on young mothers where it takes 4-7 years before mothers can conceive again. She stated that women are scared and as Members of Parliament, they can’t simply support this. She suggested that people should be given all of the information on side effects and how methods work to enable them make informed decisions.

In response to this comment, a person who is also the head of FP/SRH at Uganda Ministry of Health clarified that all FP methods may have some side effects but data shows 11 months after taking the last injection a mother can conceive. This person appreciated the Member of Parliament’s concern of equipping all service providers with adequate information and skills to communicate with and counsel clients on side effects and how methods work.

India: Is there corruption in the voucher system? How do you ensure services are delivered to the intended beneficiaries? The presenter explained that appropriate targeting is done to reach those in most need, there is careful support supervision and reporting and all stakeholders: District Health Office, Local Government structures and community-level activists accompany the poor women to the hospital. To crown it, there is a good monitoring system.

Participants wanted to know strategies in place to ensure people with disabilities get easy access FP/SRH services. The presenter from UNFPA-USA noted that people with disabilities are a special disadvantaged group with rights and needs to access health services. UNFPA has developed guidelines to help in provision of tailor-made services to suit their needs. The presenter requested that participants visit the UNFPA stall to obtain additional information.

The presenter from Uganda added that in appreciation of obstacles to access, that’s why community-based provision of FP services is being promoted. It will benefit people with disabilities who may not be able to reach health centre because of long distances.

Key Recommendations

- To increase access to family planning services in areas with low CPR and high unmet need especially in Sub-Saharan Africa there is need to use a targeted approach to reach the hard-to-reach populations normally left out in national level programs.
In promoting FP/SRH services, there is need to strongly embed them into national development strategies and policies to influence resource allocation for the programs to reach those in most need: the rural poor and other disadvantaged groups.

There is no one road to successful FP/SRH programming. It requires a good mix of public sector for supportive policy framework and free services to groups who can’t afford to pay; social marketing through a private sector at reasonable/subsidized prices and a strong BCC component to provide the information required to influence decisions and practice.

SESSION E09: WORKING TOGETHER TO INTEGRATE FP INTO OTHER ESSENTIAL SERVICES

Moderator(s): Mario Festin, World Health Organization, Switzerland

Presentations

Paper 1: Sexual Reproductive Health and Rights (SRH&R), HIV/AIDS Linkages and Integration Study in Uganda
Presenter: Olive Sentumbwe-Mugisa, WHO, Uganda
Summary of Presentation
The presenter explained the burden of HIV/AIDS in Uganda- there were 19,546 new infections among individuals age 15-49 years in 2008. This trend is worrying and is attributable to deteriorating sexual behavior. Young boys are also now starting sexual activity at an earlier age than before and there is also a decrease in condom use. The age groups that are affected most are in the reproductive age category. Therefore, they also need RH services. The main mode of HIV transmission in Uganda is through heterosexual contacts. This study was conducted in four districts and information was collected using both qualitative and quantitative methods with the aim that the information will help to improve the current HIV/AIDS and RH strategy. The findings indicate that: (i) RH and HIV/AIDS linkage exists in the policies and guidelines but its rarely used, (ii) District Health Offices (DHO) coordinates RH and HIV meetings at the district level but there is no linkages among the service providers of HIV/AIDS and (iii) RH Civil Society Organizations (CSOs) are the ones trying to integrate RH and HIV at the service delivery level. The gaps include a lack of formal link between AIDS Control Program (ACP) and the SRH programs; inequitable program support between SRH and ACP; inadequate multi-sectoral approaches; poor coordination mechanisms; more multi-sectoral linkages in HIV compared to SRH and the delink between SRH and HIV/AIDS supply chains.

Paper 2: Kenya’s National Strategy on integrating RH and HIV: Main Features, process followed in its development, lessons learned and Policy Implications
Presenter: Margaret Gitau, National AIDS and STIs Control Program (NASCOP)-Ministry of Health, Kenya
Summary of Presentation
The presenter narrated how RH and HIV programs and services provision were integrated in Kenya. The reasons for the integration included the commonality of needs of clients seeking both services. The linkage in RH and HIV programs and services are vital in meeting the Kenya’s Health Sector Strategic Plan (HSSP) targets. The Ministry of Health of Kenya recognized that for integration of the two, there is need for good policy environment, increased resource allocation, strengthening of the capacity at all levels for integrated service delivery, improved supply chain management and creation of demand for RH and HIV quality services and establishing monitoring and evaluation mechanisms. The process for the integration involves reviews of various studies RH/FP and HIV strategies and international models; development of selected RH/HIV integration models and stakeholders consultation. A supportive environment, availability of guidelines, broad based HIV/RH integration committees, evidence-based decision-making and the willingness of stakeholders to try new approaches enabled the process. Despite this success challenges still linger. These challenges include the issue of comprehensiveness in the service provision, segmental versus integrated training, integration of reporting tools, sustainability of the initiated efforts, and the shortage of human resources.
Paper 3: Integrating of Healthy Timing and Spacing of Pregnancy into Child Health Services in Rwanda: An Essential Child Survival Intervention

Presenter: Halida Akhter, BASICS

Summary of Presentation

The presenter gave a background on why to integrate Healthy Timing and Spacing of Pregnancy (HTSP) into child health services. Unacceptably large numbers of children die before their fifth birthday and the number of women dying due to birth related complication are high. Using information from Rwanda’s 2005 DHS, BASICS was able to demonstrate that spacing of pregnancy by 36 months or more decreases the neonatal, infant and under five mortality rates by 80%, 52%, and 44% respectively. BASICS used two approaches to ensure that HSTP is integrated into child health services. First, they integrated it through the use of evidence-based advocacy to target policy makers. They also used detailed programmatic guidelines to orient integration of HSTP in every routine child health services at facility and community levels. HSTP is now integrated into IMCI training guideline. Mothers who take children to child health clinics can now receive FP messages and services that they would otherwise miss without this integration. Health service providers’ capacity has been enhanced. To do this, BASICS placed a MCH/PMTCT technical advisor at the national level, built the capacity of health care workers, helped in the supervision and mentoring at the district level and encouraged partnership with other stakeholders.

Paper 4: Implementing a Sustainable Integrated MCH/FP/RH Model

Presenter: Lynne M, Pathfinder International, Egypt

Summary of Presentation

Pathfinder International, with funding from USAID, implemented a project (Takamol) to integrate MCH/FP/RH services in Egypt with an overall objective of achieving sustainable reduced fertility rates. The presenter recognized the achievements of the vertical approaches that helped in reducing the fertility rates in Egypt from 5.3% to 3% from the 1980s. However, the vertical approaches miss several opportunities to provide care. Takamol used a holistic approach to ensure integration and sustainability. This approach included: improving the quality of services through renovation of facilities, training PHC staffs (it design on job training to enable the trainee apply what they have learnt in their local settings) and enhancing the supervisory capacity of the district teams, mobilizing the communities to create demand and adopt healthy behaviours, activating service improvement funds, and building the capacity of ministry of health at the national level. Health workers were trained to offer an integrated services to clients for example giving FP information during ANC. Fifteen months after the closure of the project, there was still an increase in the ANC case load and this is positively correlated with the uptake of FP. The couple years of protection (CYP) also increased by 30% of the baseline.

Discussion

No discussion was held following the presentation due to limited time

Key Recommendations

- Integration approach is congruent with ministries of health policies and programs.
- Integration is also an opportunity to strengthen existing FP services, ensure broader cultural acceptability, helpful in reducing workload of the health workers and leads to improved services delivery including FP uptake sustained advocacy.
- Broad based integration committees are a prerequisite in steering an integration process.
- Teamwork and commitments by stakeholders is very important if integration is to be achieved.
- Monitoring and Evaluation including constant documentation is also paramount in the integration process.
- Integration usually leads to increase use of the services and this is important in the FP uptake.
- Leverage of resources from either of the programs when they are integrated this is important in the effective implementation of the programs.
SESSION A10: IMPROVING FP THROUGH COMMUNICATION AND CLIENT-CENTERED CARE

Moderator(s): Gulen Arzum Ciloglu, CARE International, USA

Presentations

Paper 1: Engaging Malian Religious Leaders on the Issue of Male Involvement in FP
The presenter explained that in Mali, the unmet need for FP is 31.2%, modern contraceptive prevalence is 6.9%, MMRatio is 464/100000 live births, and the TFR is 6.5 children/woman. Religious leaders are among the most influential and most respected people in the society and religion plays an important role in terms of couples’ decision to use modern contraception methods. The USAID Health Policy Initiative conducted meetings between religious leaders and patients in clinics, policy dialogues sessions about FP facilitated by religious leaders and exchanges about role of men in FP. Findings showed that in 2008, the Ministry of Health adopted guidelines for CME-FP and Muslim leaders implemented the guidelines. Muslim women participated in policy dialogue sessions with their spouses on child spacing and religious leaders spoke openly about FP. Mali has seen an increased use of FP. Pillars of success include community involvement, the inclusion of religious leaders in drafting guidelines and doing research about Islam’s point of view on FP. Lessons learned include that the community’s involvement is essential, to advocate for FP to promote maternal and child health, and that religious leaders are potential allies for promoting health programs.

Paper 2: Designing a Family Planning Campaign for Rural Women in Zambia
Presenter: Uttara Bharath Kumar, Health Communication Partnership, Zambia. MoH.
The presenter informed us that Zambia’s DHS (2007) indicated concern among Zambians about methods for FP, a desire for large families among men, and limited knowledge of different FP methods as the main reasons for people not using FP. Forty two percent of women said their last baby was unplanned. The maternal mortality ratio in Zambia is 591 maternal deaths/100000 live births. There were existing tools for health providers including wall charts, family planning glossary, community health information cards and video tools for family planning. However there wasn’t a national campaign to pull all of these tools together and raise awareness about FP. The multimedia approach used print, radio and video since media in Zambia not saturated and population generally listens to community radios. The aim of this program was to increase approval and use of modern FP, promote contraception as “family planning” and not “birth control” and raise public awareness of FP. Researchers found that exposure to the campaign and VCT for HIV raises contraceptive prevalence. The campaign is in its initial stages but so far seems to be successful and popular.

Paper 3: Expanding Technical Capacity in conflict settings: Leveraging Networks to strengthen FP programs
Presenter: Katie Mary Anfinson, American Refugee Committee
Leveraging partnerships can expand programs and the presenter reported that the RAISE initiative focuses on provision of integrated comprehensive reproductive health. The American Refugee Committee (ARC) aims to improve quality and access to services and to strengthen health information systems among other things. As a RAISE partner, ARC is part of a network of providers, advocacy professionals and technical specialists focused on RH and FP. Challenges for refugee health include lack of services available, lack of skilled staff, lack of knowledge and no availability of FP commodities/options. Due to lack of integration of FP in refugee services, the health technical team has not been able to meet support demands for refugee field staff. ARC was able to leverage external support by using partnerships to improve technical ability. For example, the fellowship in FP allows fellows who are medical professionals to work internationally and ARC placed fellows in Darfur and Rwanda. These fellows provide daily support and guidance on FP. Subsequent fellows provided follow-up training. Because of the skills of each fellow, they became technically qualified professionals with field and management experience. They also
became more familiar with the challenges and the meeting staff they would be working with later at headquarters. Results of the intervention included the increased ability to meet technical demands from the field and long-term partnerships. Lessons learned included that professional networks help organizations to increase access to FP and RH programs and contribute to stronger impact of services and increased technical supports.

Paper 4: Reducing Fertility in Ethiopia: Results of a Radio Station Serial Drama.

Presenter: Kriss Barker, Population Media Center, South Africa.

The presenter noted that Ethiopia has the second largest population in Africa. The Population Media Centre (PMC) works with media to produce and broadcast soap operas and radio dramas. PMC programs have been successful in producing behavioral change. This is because extensive formative research is conducted before starting programs in an attempt to get to know the audience. The presenter recommended the use of Sabido methodology. Soap operas are effective because they are long-running allowing time for audiences to bond and characters to evolve. They are also melodramatic to address highly charged issues in an entertaining way. In Ethiopia PMC produced Yeken Kignit (drama) and 46% of the population said that they saw it. The researcher conducted thorough evaluation of health center assessment, baseline and impact assessments. They found that 63% of new clients at the health center said they listened to program. Female listeners tested 3 times more than non-listeners and male listeners also tested more than non-listeners. An independent researcher did impact evaluation. The fertility rate in Ethiopia dropped from 5.4 to 4.3% within the two year period during which drama was ran. The demand for contraception increased too.

Discussion

A participant from Uganda said his organization uses a lot of serial drama. However, the greatest challenge is sustainability. Private media houses may gain from the program but they still want the organization to pay. In response to this, the PMC presenter said they should take the program to the station and focus on guaranteeing that they will get listeners/viewers. Also, the presenter suggested that they should look for government sponsorship and also suggested to coordinate with communication (cell phone) companies. Another participant wondered what experience PMC had found in other places such as Niger with media dramas. The presenter responded that they don’t incite demand for non-existent services; there are no services (PMC) in Niger.

A participant asked what was the policy dialogue they have been focusing on in Mali? The presenter responded that since men are involved in decision-making, there is a need to have dialogue among the partners in the couple. This makes the involvement of men extremely important. This is why policy is focused on dialogue with men and couples.

There was a concern that since CPR in Zambia is 33%, why was the unmet need for FP at that level of CPR. The presenter responded that the Population Growth Rate of Zambia is 2.9% and unmet need is 27%.

A participant who works with mass media campaigns suggested that presenter show a dose response relationship (in further presentations) with the number of programs watched and use of contraception by method for the Ethiopian drama. She also suggested that PMC shouldn’t claim full credit for drop in fertility rate as communication is process and there are other factors. The presenter responded that no dose response relationship was studied and she merely claimed that power of program did surpass initial expectation but was not taking full credit for drop in fertility rates.

Key Recommendations

None provided.

SESSION B10: NOT RECORDED.
SESSION C10: INNOVATION IN KNOWLEDGE SHARING AND NETWORKING FOR FAMILY PLANNING: HOW TO MAKE A DIFFERENCE

Moderator(s): Susan M. Reier, World Health Organization, Switzerland

Presentations

Paper 1: Applying results of a global needs assessment: How can we make the latest health information easy-to-find and easy-to-use for Health professionals?
Presenter: Meghan O’Brien, Center for Communication, USA
Summary of Presentation
The presenter highlighted a finding from a multi-country needs assessment carried out by Knowledge for Health project (K4Health). It was designed to answer what health information key audiences in health service provision need, what type of infrastructure is available to support information and communication technologies, what are the most promising technologies, what available information networks exist and challenges to accessing and using up-to-date health information. To answer these questions, they collected information online and also used a variety of qualitative data collection methods in a multi-country survey. The results indicate a lack of reading materials especially in developing countries and poor reading culture when materials are available. Sometimes the materials are even irrelevant to the local setting. The other findings include the high cost of internet and its slow speed and lack of availability in rural areas. The main sources of information are journals articles, handbooks, and fact sheets. In terms of electronic media, the top sources of information are web search engines, online training, databases, CD ROM and forums. Basing on the findings, K4Health contends that assessing health information need is important step in meeting demand and creating useful resources. K4Health is utilizing this assessment to make it easy to assess health information online without neglecting the older technologies for information packaging.

Paper 2: International Association of Public Health Logisticians: Laying the Foundation for a Vibrant Online Community of Practice?
Presenter: Hamisu Hassan, John Snow, Inc/ Making Medical Injections Safer (MMIS), Nigeria
Summary of Presentation
The presenter highlighted the challenge of the limited number of forums that exist for the supply chain professionals in developing countries. A variety of forums are quite vital for information sharing, brainstorming on topical issues to address emerging challenges and stimulating new innovations. Against this background, International Association of Public Health Logisticians (IAPHL) with support from USAID DELIVER Project was formed to try and address some of the challenges that public health logisticians face. IAPHL was formed in 2007, and has established its website that can be assessed through a sub-site on implementing best practices (IBP) knowledge gateway. Members usually participate in discussions online on topical issues. IAPHL has also managed to create a virtual community of practice. IAPHL now boast of 373 members in 62 countries. IAPHL also encourages in-country members to have face-to-face discussions especially where they are ten or more. IAPHL’s survey of its members indicates that they value best practices, discussions on topical issues and sharing of experiences of members through the association.

Paper 3: Creating Knowledge Pathways to Improve Reproductive Health
Presenter: Maggie Usher-Patel, World Health Organization
Summary of Presentation
The presenter said Implementing Best Practices/Knowledge gateway (IBP/KG) is a networking tool designed to support virtual communities of practice (COPs) to have online discussions especially around reproductive health related topics. The presenter contends that there is enormous body of knowledge, but it does not get translated into work/practice. This is a big challenge that IBP/KG seeks to address. WHO and INFO project at the Center for Communication Program, Johns Hopkins School of Public Health developed IBP/KG. WHO and IBP partners provide technical expertise to support various agencies to
develop, own and manage their own COPs. This tool is designed to work as well in areas with technological challenges such as slow connectivity. The discussions can also be assessed through the regular emails; it is a very easy to use networking tool and it is quite useful for planning and coordinating group work. Topical issues are usually identified and submitted for discussion. At the end of the discussion the notes are summarized into useful information. The benefits of IBP/KG include networking and communicating with other interdisciplinary communities, synthesizing information and reaching other people more effectively.

**Paper 4: The Ten Elements of Family Planning Success: Engaging FP Professionals Worldwide to Identify Factors for Success**  
**Presenter:** Mitchell Vanessa, Center for Communication Programs, John Hopkins School of Public Health  

**Summary of Presentation**  
The presented said the INFO project at the Bloomberg School of Public Health used multimedia tools to identify elements of FP success from a cross-section of health care professional and FP professional globally. The process was carried out in three stages. Firstly, an online survey was done to identify the elements that are important in FP and those difficult for program achievement. Secondly, the most important elements were discussed on a virtual forum created on implementing best practices (IBP) knowledge gateway. The final stage was basically sharing of the resources; the INFO project team developed a package of resources based on the survey including a social networking site [http://www.fpsuccess.org](http://www.fpsuccess.org). The initiative came up with ten topmost important elements for FP success, but these are also the most difficult for programmatic achievement. To note in this process is the importance of the participatory approach that ensured the respondents expressed FP needs and that effective knowledge management is vital for professionals because this caters for their needs. It also promotes knowledge sharing.

**Discussion**  
The issue that the participants raised most was the access and utilization of information, including sharing of information by professionals in developing countries. Of particular concern was access to the internet to enable them to participate in virtual forum discussions. The presenters acknowledged this, but agreed that newer technologies were essential but the older ways to package information should not be neglected. On the point that slow internet connectivity that may hinder usefulness of K4Health utilization, the presenter said the discussion can still be done if one can access their emails. On whether the social networking site established for FP success will close the presenter said she is not sure when it will close, but even if it get closed the toolkit will be transferred to IBP K4Health website.

**Key Recommendations**  
- Knowledge sharing is crucial especially for acquiring evidence-based ways for implementing best practices.
- Communities of Practice is helpful in identifying topical issues including technical questions that lead to online discussions and this is helpful in circumventing some of the challenges that professionals face.
- In case professionals are not in position to access internet other methods like video, radio, prints, working groups, etc, can still be used.

**SESSION D10: GENDER AND REPRODUCTIVE RIGHTS: THE FOUNDATION OF SUCCESSFUL FAMILY PLANNING PROGRAMS**  

**Moderator(s):** Janet Jackson, UNFPA, Uganda
**Presentations**

**Paper 1:** The Development and Testing of a Programming Model for Addressing the Role of Men in Family Planning  
**Presenter:** Theresa Castillo, EngenderHealth, United States of America  
**Summary of Presentation**  
A literature review was conducted to examine the different types of interventions that have been implemented to address FP and RH issues that explicitly engage men in the last 10-15 years. Very few studies addressed gender norms and social constructions of masculinities. From this review, a logic model for addressing the role of men in family planning was developed that highlighted potential interventions for addressing demand, supply and advocacy for men and family planning. Potential interventions to reach men include BCC/IEC, testimonials, peer education, male-friendly services, improved counseling, celebrity support, media, and political support. Pitfalls for interventions that address the role of men in FP include messages that reinforce harmful constructions of masculinity, biases or unintended outcomes from couple centered approaches, and missed opportunities to reach men. The model was brought to Tanzania, Ethiopia and Bangladesh. It was recommended that programs should be multi-faceted and address issues related to demand, supply and advocacy.

**Paper 2:** Evidence-Based Guidelines for Addressing Adolescent Contraception in the Context of Conservatism, Poverty and Gender-Based Violence: A Peruvian Study  
**Presenter:** Maria Raguz, Pontificia Universidad Catolica del Peru, Peru  
**Summary of Presentation**  
The presenter emphasized that Peru is among the top worst countries for gender indicators in the world. Strong religious views on top of a violent and patriarchal society have contributed to this situation. Being an adolescent female in Peru results in specific sexual and reproductive health risks. A qualitative study was conducted in 2007 with adolescents using interviews, focus group discussions and other methods such as life stories in three peri-urban regions of Peru. From the study, it was found that adolescents have inadequate knowledge and negative attitudes toward sexuality and contraception. Common beliefs about contraception include that it is only for marriage, it harms the body and soul, and it makes women promiscuous. Adolescent respondents reported using traditional methods and were fearful that their parents would discover they had a boyfriend. The presenter explained that risks go beyond unwanted pregnancies and include being controlled by men and being victims of violence. Multi-layered action is recommended that acknowledges gender-based violence and gender inequalities.

**Paper 3:** Constructs of Power and Equity, and Their Association With Contraceptive Use Among Men in Africa.  
**Presenter:** Mary Yetter, CARE, United States of America  
**Summary of Presentation**  
The presenter described findings from analyses of three baseline surveys in Kenya, Ethiopia and Rwanda. The questionnaire was adapted from DHS and included a 26-item scale. The questions for the scale were adapted from the Gender Equitable Men (GEM) scale and the Sexual Relationships Power Scale (SRPS). In both Kenya and Ethiopia, over 40% of respondents wanted to delay or limit childbearing. Men had more equitable attitudes in Ethiopia. A positive association was found between contraceptive use and the gender equity attitude score among men and women. Additionally, a positive association was found between contraceptive use and men’s perceived high power, however, women’s perceived high power did not affect contraceptive use. These results suggest that power dynamics are important in contraceptive use and there is a need for interventions that target men. Different strategies are needed for men and women. Further understanding is needed regarding why certain attitudes of gender and power persist.

**Paper 4:** Promoting Sexual and Reproductive Rights: A Rights Based Approach: Columbia  
**Presenter:** Mona Kaidbey, UNFPA, United States of America  
**Summary of Presentation**  
A study on the impact of a national multi-media strategy that aimed to strengthen individual capacity to exercise their reproductive rights and responsibility, improve the capacity of health care providers to
increase access to SRH services, and guarantee the implementation of national guidelines for increasing the demand and utilization of services. A reproductive rights-based approach was used for the campaign. The program focused on 6 departments of Columbia and targeted youth, adults, providers, institutions and administrators. Through various mediums, messages such as “know your rights, take matters into your hands” were delivered. Mixed-methods were used to evaluate the impact including external evaluation, qualitative methods, and pre/post assessment. The findings suggest an increase in knowledge of reproductive rights, an increase in knowledge of how to prevent pregnancy, and an increase in the number of adolescents who know how to protect themselves. The reproductive rights framework enabled the empowerment of youth, increased communication, and increased the demand for youth-friendly services. The media was an effective way to look at gender-roles in a non-threatening way. The linkage between the health and education sectors was crucial for sustaining the impact of the program.

Discussion

Several questions were raised to the second presenter about Peru on how the government and legislation play a role in gender issues, such as gender-based violence. The presenter reported that there is a gender-based violence policy that focuses on domestic violence but not structural violence. Additionally, the presented informed the audience that emergency contraceptive pills were just made illegal in Peru and that there is currently a proposal to make all contraception illegal. Other recent changes include a disappearance of sexual education and a decrease in funding.

Another audience member asked the fourth presenter whether there were internally displaced people (IDPs) in any of the six departments where the program was implemented. The presenter noted that the program started in an area with IDPs and that there is a real need to build trust in these areas. An additional question was asked about what strategies are used to ensure that the needs of women with disabilities are being met. The presenter noted that WHO and UNFPA are working on this issue by developing more guidelines.

Key Recommendations

- A reproductive rights framework has the potential to give people skills, confidence and trust to demand their rights.
- The study in Columbia found success using a multi-media strategy. This strategy can provide a non-threatening way of looking at gender roles.
- More research is needed to understand why certain attitudes about gender and power persist throughout Africa.
- Based on the results from the study conducted in Kenya, Ethiopia and Rwanda (third presentation), family planning interventions should consider the power dynamics of couples.
- In Peru, a multi-layered approach that acknowledges gender-based violence and gender inequalities is needed to address adolescent sexual and reproductive health.
- Based on an extensive literature review and field-testing in three sites, a multi-faceted programming model should be used in programs involving men in family planning.
- The first presenter warned of intervention pitfalls that can occur when involving men in family planning including messaging that reinforces harmful constructions of masculinity, unintended outcomes from couple centered approaches, and missed opportunities to reach men. These issues should be considered in the development and implementation of interventions.

SESSION E10: HEALTH SYSTEMS STRENGTHENING: WHAT TO TARGET FOR SUSTAINABLE, QUALITY FP SERVICES

Moderator(s): Eduard Bos, World Bank, USA
Presentations

**Paper 1: Improving RH outcomes through Health Systems Strengthening: An Overview**  
**Presenter:** Ayman Mohsen and Barbara Seligman, Abt Associates, United States of America  
**Summary of the presentation**  
The presenter explained that the objectives of a health system which include good health, responsiveness, financial protection, and improved efficiency. These objectives can be achieved through service delivery, health workforce, information financing and leadership/governance. However, obstacles include poor staff motivation and financial barriers that hinder use of FP/RH services among the poor. The presenter also noted some truths about health systems strengthening. For example, health systems strengthening is not prescriptive, it is evidence based and tailored to the country’s circumstances. Generally, there is an indirect link between HSS and health outcomes, and it is a long-term investment.

**Paper 2: The Contribution of the Botswana Family Planning Program to the Largest Fertility Decline in Sub-Saharan Africa.**  
**Presenter:** Veronica Leburu, Sexual and Reproductive Health Manager, Ministry of Health Botswana.  
**Summary of Presentation**  
The maternal and child health/family-planning unit was established in 1973 in Botswana and from the outset, FP was integrated in Primary Health Care Services. The majority of the services were provided at lower level facilities and not necessarily hospitals and this increased accessibility in both rural and urban areas. Furthermore, there was an extensive training of health personnel and the capacity of NGOs to improve outreach services to the youth was strengthened. For the purposes of monitoring and evaluating the FP program, data was collected using the routine Health Management Information System and several national population-based surveys. As a result, Botswana has the highest Total Fertility Rate (TFR) decline in Sub-Saharan Africa. It also has impressive RH indicators such as the use of antenatal care at 97% and the use of health personnel for delivery at 98%. Some of the lessons they learned were ensure access to and quality of FP services through integration of MCH/FP/HIV/AIDS services at all health facilities, generate demand for FP services, strengthen program management, and invest in the education of girls.

**Paper 3: Bangladesh Ministry of Health and Family Welfare Structure and Systems**  
**Presenter:** Ahmed Al Kabir; Research, Training and Management International, Bangladesh.  
**Summary of Presentation**  
Using an organogram, the presenter illustrated the structure and system of the Ministry of Health and Family Welfare in Bangladesh, pointing out the roles and responsibilities of policy makers and implementers. FP does not have its own structure but it is waxed within the health system. Integration of all health care services has improved the performance of all services including FP, reduced missed opportunities and improved the referral system. Integration can strengthen program performance and outputs. However, existing systems should be effectively utilized and a combination of both demand and supply side approaches should be undertaken through a bottom up approach.

**Discussion**

Responding to a question on critical aspects of the health system to which family planning can be linked, the presenter from Botswana highlighted planning together towards budgeting and financing which offers FP a standardized reference. She also emphasized that the gains in the country were not efforts of expatriates as had been suggested but by both the locals and expatriates since Botswana has developed a human resource strategy.

From the integration of FP program, Bangladesh has realized good results such as high CPR and low TFR. On the other hand, FP has lost its focus since maternal and child health is a priority. There was an argument that vertical programs were also linked with better returns in terms of finance and client satisfaction for instance. A big barrier to it is that the funding comes from different sources.
Key Recommendations

It is critical to treat the issue holistically.

SESSION F10: ADDRESSING YOUTH SPECIAL NEEDS: LESSONS LEARNED FROM RESEARCH

**Moderator(s):** Brian Chilonde, UNFPA, Uganda.

**Presentations**

**Paper 1:** Youth As Effective Role Models in Integrated HIV and Family Planning Programme in Rural Community- Lessons Learnt from a Youth FP/HIV Intervention in Nwaoriebi, Imo state of Nigeria.

**Presenter:** Cornel Ekeh, Society for Family Health.

**Summary of Presentation**

In this session, the presenter explained that the Nwaorieubi community is a high-risk community with a lot of out of school youth staying idle. Prostitution is high in the area due to the fact that the youth don’t have anything to occupy their time. The society for family health implemented this project. The baseline results showed that young people are lacking sexual and reproductive health information. Therefore, the objective of the project was to create awareness on FP/HIV, share and correct information on myths and misconceptions about FP methods. The project was implemented over a period of one year. Project activities included training peer educators who were selected from different categories of youth such as sex workers and transport men. These trained peer educators went around the community sensitizing their peers on FP and HIV and AIDS. After implementation, the evaluation showed increases in knowledge of FP and HIV. Youth were able to integrate FP and HIV in their activities. Also, a CBO was formed in the area to work on FP, HIV and other areas that affect the youth.

**Paper 2:** Reaching Young Mothers and Young Girls with Postpartum Family Planning Services in Haiti.

**Presenter:** Dr Lucito Jeannis, Jhpiego.

**Summary of Presentation**

The presenter explained that in Haiti 50% of births occur among 15-19 year olds and 24% among 20-29 years olds. Many young mothers have a second birth less than 24 months after the previous delivery. Three percent of 15 - 24 year old mothers desire another birth within two years after delivery. This problem is attributed to low contraceptive use among this population. It is also a taboo to talk about contraceptives to young people in Haiti. This project was implemented with the aim of reducing the unmet need in family planning among young mothers and girls. Three approaches were used to achieve this objective: (i) youth friendly health service training for service providers, (ii) creation of demand in SRH/FP services, and (iii) creating a supportive environment for young mothers and girls. Community orientation meetings were done to sensitize the community about family planning and this involved meeting with the parents and community leaders. Awareness meetings were also conducted to remove the myths and misconceptions about the FP. Results showed improvements in how to handle the young mothers and girls by service providers. Parents and adult support groups were formed in the community that helped in increasing acceptability of SRH services. Young mothers and girls clubs were formed and this helped in increasing the demand for FP. The project uptake was good in rural areas as compared to the urban areas due to various reasons including availability of stocks in rural areas than urban areas.

**Paper 3:** Qualitative Research to Improve Counseling on Dual Protection Targeting Adolescents in Dar es Salaam, Tanzania.

**Presenter:** Stella Mujaya, FHI, Dar es Salaam, Tanzania.

**Summary of Presentation**

The presenter explained that PEER methodology was utilized to understand adolescents’ beliefs and practices with regard to their risk for HIV, STI, and pregnancy and also identify the types of support desired by adolescents to assist them in adopting dual protection behaviors. She explained that this
methodology was useful when doing research on sensitive matters. Each interviewer interviewed 3 friends. Some of the topics included in the interviews were concerning relationships, being happy and healthy in a romantic relationship, and support and information from romantic relationships. The results showed a great need to educate the youth on condom use, on assertiveness, focus on positive messages and also the need for skill building in the youth.

Discussion

The presenter from Nigeria explained that their organisation was not the one that formed the CBO in the implementation area. Instead, the young people themselves saw the need to establish the CBO. The presenter’s organisation facilitated the linking of the CBO to the local government for support. This explanation came after one participant was worried about the sustainability of the CBO after the end of the project. This presenter also explained that they have special time as to when they engage the sex worker since they do operate differently from other youth in the community so special session a done to address their problems.

All presenters agreed that the involvement of the youth themselves in the project was vital since they assisted in the easy implementation of the project. By owning the project and also motivating other youth to join the project, these youth acted as models to fellow youth. Therefore, good results were seen from the projects and this also guarantees sustainability of the projects.

Key Recommendations

- Young people should be involved in the design and implementation of the projects that affect them for the sake of the sustainability of the project.
- Young people needs to be trained in life building skills so that they should know how their bodies function and also know where to seek SRH services without feeling shy or unsafe.
- Service providers should not have judgmental altitude on the youth when they come to seek SRH services because this makes they youth not to come to seek the services
- Messages to the young people should be packages well to suit different age groups and also categories of young people according to what they do in the society. Community based interventions are proving to be affective than clinic based so there is need to focus more on the community than clinic for youth services.

CB01: THE MISSING LINK: THE MANAGEMENT OF CHANGE TO SCALE UP EFFECTIVE PRACTICES

Facilitators: Tim Allen, MSH; Joan Mansour, MSH; Maggie Usher-Patel, WHO/RHR; Nandita Thatte, USAID; Jason Smith, FHI

Overview: We have the knowledge and technology to improve reproductive health. Our challenge is overcoming barriers to implementing and taking to scale what we know works. A missing link is the ability to manage a process of change required to support the introduction, adaptation, application and scaling up of proven effective practices. This workshop will demonstrate how using evidence-based change practices can significantly increase the chances for success and sustainability.

Introduction to Leading and Managing Change (1 ½ hour): This ninety minute session introduces participants to the fostering change methodology and gives them the opportunity to explore the change process.

Objectives:

In this session participants will:
• Explore the principles and phases of the fostering change methodology and apply them to a case study analysis
• Discuss how the fostering change methodology applies to implementing and taking to scale an actual practice they are currently working with or would like to work with

CB02: USING FP TOOLS: WHO GUIDANCE AND PROVIDER CHECKLISTS

Facilitator: Eva Canoutas, FHI

The World Health Organization (WHO) has established through the Medical Eligibility Criteria for Contraceptive Use (MEC) global guidance for using various contraceptive methods. Related tools provide guidance and recommendations for actual practices by providers, including how to guide users in making decisions. These cornerstone documents on family planning guidance serve as the foundation for other evidence-based tools used in promoting greater access to contraceptive methods.

The workshop would introduce the WHO cornerstone documents, including a job aid known as the MEC wheel, along with a package of five family planning checklists developed by FHI and now widely used by family planning programs globally. The checklists are designed to screen women who want to initiate use of combined oral contraceptives (COCs), the injectables DMPA or NET-EN, an IUD, or implants. The fifth checklist helps providers rule out pregnancy among non-menstruating women seeking to initiate the contraceptive method of their choice. Participants will gain an understanding of what these tools are and get some experience in using them. The checklists and the MEC wheel will be available to all participants with references to related tools.

CB03: SCALING UP FROM THE START: BEGINNING WITH THE END IN MIND

Facilitator: Trinity Zan, FHI

This workshop emphasizes the importance of engaging stakeholders potentially involved in scaling up an innovative service approach at the beginning of a research/intervention project. Scale-up is often discussed only after the research is over. Engaging stakeholders through the life of a study can help ensure relevance and replicability of the innovation, including the types of data that are needed and how to implement the intervention. The workshop will cover three key phases of this scale-up approach, shown below with illustrative activities:

• Research Conceptualization: include scale-up implications/possible activities in concept development and research plan; identity/engage stakeholders to help inform the study design and stay engaged during the study

• Implementation: use tracking tools to help determine what components of the intervention are critical for scale-up, including cost data; identify policy issues relevant to the eventual scale-up; develop effective advocacy strategies for study results

• Dissemination and Utilization: as part of routine dissemination, include site visits and key informant interviews to identify key lessons for possible scale-up; include stakeholders in a systematic review of study findings and development of approaches to a scale-up strategy
CB04: REALITY CHECK: A FORECASTING TOOL FOR EVIDENCE-BASED PLANNING AND ADVOCACY

Facilitator: John M. Pile, EngenderHealth

Programs need data to garner political and resource support, and for planning evidence-based goals, activities and resource deployment. Yet program planners, managers, and implementers often lack the data and tools they need to make realistic programming decisions.

This workshop will introduce participants to Reality √, an Excel-based family planning forecasting tool developed by The ACQUIRE Project and EngenderHealth that can be used to generate data for evidence-based planning and advocacy. The tool examines the relationship of contraceptive prevalence to contraceptive users, adopters, commodities, commodity costs, and service-delivery capacity, based on demographic data. Reality √ enables the user to rapidly assess the feasibility of program goals, and to forecast the resources needed to achieve different “what if” scenarios at multiple levels (national, regional, district). It generates data needed to advocate and to plan for service delivery expansion.

The workshop will use a mix of presentations and practice through group exercises to demonstrate how the tool can be used to assess past contraceptive trends and test feasibility of established or proposed goals, and project commodity and human resource requirements to meet these goals.

CB05: TIPS AND TOOLS FOR FP ADVOCACY

Facilitators: Rhonda Smith, PRB and Freddie Ssengooba

To help bridge the knowledge-to-action gap, the Makerere University School of Public Health and the Population Reference Bureau are co-facilitating a skill building session dedicated to advancing policy–level advocacy for family planning. Using an interactive approach, the session facilitators will present tips and lessons learned in reducing the knowledge-to-action gap, facilitate an exchange of experiences, and review the latest advocacy tools, including the new toolkit: Repositioning Family Planning: Guidelines for advocacy action.

The goal of this session is to provide participants with a roadmap for policy advocacy, based on state-of-the-art concepts and techniques for reaching policymakers and affecting policy change. Specifically, participants will:

- learn the 6 top lessons from experiences in bridging the research-to-policy gap;
- become familiar with a simple framework for conceptualizing the knowledge-to-action process;
- explore how knowledge can influence policy and identify the evidenced-based factors that can accelerate the process;
- discuss advocacy barriers and successful approaches for informing policy development; and
- review the latest in family planning advocacy tools and resources.

The workshop will consist of a combination of plenary and small working-group sessions emphasizing a hands-on, participatory approach. Participant will have an opportunity to share experiences and will receive a packet of current family planning advocacy materials and guidelines.
CB06: DOCUMENTATION OF “PRACTICES THAT MAKE PROGRAMMES WORK”

Facilitators: Suzanne Reier, WHO/IBP; Maureen Kuyoh, FHI/Kenya; Solomon Marsden, FHI/Kenya

In any given country, a number of best, good and/or promising practices are being implemented. Often these are being conducted as pilot projects in one part of the country or even in the same part of the country but through different groups. Ministries of Health, often with assistance from donors, NGOS, and private sector groups may be carrying out innovative programmes or using evidence-based practices which others could benefit from, however others are unaware of the results or existence of these programmes.

Although many organizations and countries are now beginning to see the importance of documentation of "best" practices, it is important to go further. Documentation is not done for just documentation purposes and is part of a larger process to advocate and improve programmes within a country or region.

This session will work with participants to:

- Identify lessons learned from documentation experiences in countries such as Ethiopia, Kenya and Benin.
- Discuss terminology and implications
- Discuss essential steps in the documentation process
- Identify next steps for integrating documentation results into planning and programme development

CB07: “SOCIAL ANALYSIS AND ACTION” APPROACH

Facilitators: Gulen Arzum Ciloglu and other CARE Representatives

Programs at local, national and international levels have attempted to “mainstream” gender in order to address gender inequality and systemic marginalization of women in societies around the world. While en vogue for over a decade now, “gender-mainstreaming” has achieved only limited success in terms of transforming organizations and societies. CARE's work in sexual and reproductive health (SRH) has increasingly focused on identifying and tackling social norms that perpetuate poor health outcomes. In addition to strengthening service delivery and health systems, CARE emphasizes gender equity and sexuality as key social determinants of health. CARE’s innovative approach challenges staff and partners to examine their personal values and how they relate to improving SRH. CARE's SRH team will guide participants through the “Social Analysis and Action” approach that enables communities to identify and explore social conditions that perpetuate health challenges. This session will explore how health and development programs can be more explicit in working through socially defined constructs such as gender and sexuality focusing on skills building through the use of innovative tools and methodologies for exploring staff and community transformation.

CB08: IMPROVING TECHNICAL ASSISTANCE WITH A FOCUS ON EVIDENCE-BASED PRACTICES

Facilitator: Nandita Thatte, USAID

The USAID Office of Population and Reproductive Health (PRH), through its implementing partners, has consistently led the way to develop evidence based products, practices and tools, to improve family planning (FP) outcomes worldwide. However there have been gaps in ensuring that these results are being adopted uniformly throughout our country programs.
Though technical assistance (TA) directly to country projects and bilateral programs has been quite regular, TA from USAID/W to Missions varies by country and has been less systematic. In this session we highlight an approach for systematic TA to country Missions particularly for assessments of FP programs, development of country-level strategies, program design, post-award technical assistance, and ongoing monitoring and coordination.

In order to further strengthen this approach to providing TA we are developing an illustrative set of evidence based tools, practices, and approaches to aid achieving family planning objectives.

Participants will be able to:

- Identify various types of TA provided by USAID/W to country projects, bilateral programs and Missions
- Dialogue about how USAID/W can provide effective TA to
- Discuss how the USAID/W can support country Missions, bilateral programs and projects to adopt evidence based practices

CB09: FEMALE CONDOM PROGRAMMING

Facilitators: Ilze Smit, Lucie van Mens, Hendrick Salla, Victoria Archibong, Universal Access to Female Condoms Joint Programme

The skill building workshop on will tap from the experiences of the development of two large-scale female condom UAFC programming, one in Cameroon and one in Nigeria. Essential elements in female condom programming are demand creation, supply chain management and involvement of men. In this workshop the following topics and questions will be discussed:

1. Information Education and Communication (IEC) for demand creation: how to develop the materials? What is important in a mass-media campaign on female condoms? How to involve famous artists? Which information messages are important in the IEC?

2. Supply chain management: Where should the female condom be available? How to get it there? What is needed to fill the pipeline? Are there differences if you introduce more than one female condom model in the market?

3. Involvement of men: Research and long experience in female condom programme has proven that involvement of men from the beginning is key to the success of the programme. Which men to involve? How can they be involved? How can they be approached best, men as consumers?

18 NOVEMBER 2009 – DONOR PANEL

Session Chair: Dr. Jotham Musinguzi

Panelists:
- Dr. Scott Radloff, USAID
- Mr. Jose (Oying) Rimon II, Bill and Melinda Gates Foundation
- Dr. Sadia Chowdhury, World Bank
- Mr. Jagdish Upadhyay, UNFPA
- Dr. Michael Mbizvo, WHO
- Mr. Anthony Daly, DFID
Dr. Jotham Musinguzi opened the session by thanking the donors for their participation in this session. He explained that, in order to guide the discussion, two questions would be posed to members of the donors’ panel.

**Question #1:**

Family planning has been on the agenda of governments for some time. Do you feel there is a renewed attention and commitment to FP at this time and to what extent do you think MDG-5 serves as a galvanizing framework? As a donor, what do you see as the opportunity for this moment and what stands in your way to fully utilize this moment?

*Mr. Jagdish Upadhyay, UNFPA:*

Family planning has its ups and downs, but we must be sure it gets the needed budgetary requirements and is owned by local governments. We should look at family planning from a broader stance. For example, rather than only thinking about the health benefits of family planning, we should think about gender issues and reproductive rights. The role UNFPA is playing is to strategize about family planning from a broader perspective rather than focusing on just one aspect.

UNFPA is also, however, working in specific areas such as contraceptive security. UNFPA is leading the reproductive health supplies coalition, which is made up of 10 donors and partners. This group facilitates donor coordination and helps to avoid contraceptive stock-outs by anticipating where diminishing supplies may be a problem. One challenging issue this group is thinking about is how a procurement mechanism can be implemented at a global level.

Donors need to think about bigger money, not just more money. We all need to strategize about how to avoid duplication in efforts. We will have to work together and coordinate our efforts, and we can use the renewed energy around family planning to do this.

Last year, donors contributed $214 million for contraceptive supplies. This may increase to $250 million next year, but on the first day of the conference we heard that we need $43 billion to meet contraceptive needs globally. We need not only more money but smarter money.

In terms of monitoring and evaluation, UNFPA will analyze the 2010 census data to track progress in meeting the MDGs. Advocacy is also important. Depending on the global economy, donor support may ebb and flow. Therefore, UNFPA is working with Ministries of Finance and parliamentarians to make sure maternal and child health stays funded in national health budgets.

*Dr. Michael Mbizvo, WHO:*

There are several take home messages from the past few days. First, we should have a greater appreciation for the benefits of family planning. The success of family planning programs underpins achieving all of the MDGs. Family planning is a development, health and human rights issue. It contributes not only to maternal health, but also to other types of health.

Second, we have lost ground in achieving the MDGs. Target 5b is universal access to reproductive health care, which was articulated in 2000 but will unlikely be achieved by 2015. Family planning has been on the agenda of governments for some time now. We are at this meeting as service providers, civil society and media. We each have a role to play in reaching the MDGs. We should use our leverage and our complementary attributes to reach this goal.

Third, we need to think about how to reach the unconverted. We are all believers in family planning at this conference, but how do we reach political and religious leaders? We need to repackage our communications strategy, and we need a strategic approach for each target contingent. In particular, communities are part of our network, and we need to identify family planning champions at grassroots
levels. We have now strong evidence to use in our advocacy for family planning. We should avail ourselves of constant updates in family planning evidence to inform our work.

Dr. Khama Rogo said that family planning is to maternal health what vaccination is to child health. We must appreciate the benefits of investing in family planning and remember that upstream investment saves long-term costs. The cost of an IUD now saves us the costs of an unwanted pregnancy later, lost lives of women and unschooled children. We need to use this as an advocacy tool and explain how addressing family planning needs now saves us from addressing unmet need later.

Mr. Jose (Oying) Rimon II, Bill and Melinda Gates Foundation:

I would first like to confirm what could be a biased observation. Is there electricity and energy among us? “Yes!” [from audience]. Three years ago, if you asked me if the MDGs were understood by the U.S. Government or by the foundations, I would have said the MDGs had no meaning to those groups at all. Today, that has changed. President Obama has said the U.S. Government will adopt the MDGs as part of its foreign policy agenda. This is an incredible change. The president of global health for our own foundation, in many of our staff meetings and in speeches outside, says our global investments must continually further efforts to achieve the MDGs. The MDGs now guide our strategic thinking.

However, resources are finite. At the Gates Foundation, we have strategically decided to invest in advocacy and policy. In this way, we can multiply our investment by making sure funds for family planning are availed in the future by other funders and local governments. It is not feasible to achieve MDGs without investment. That is why we have recently invested in the U.S. to make sure U.S. decision makers take family planning seriously. We have also invested in Europe to make sure their strong support for reproductive health continues. As part of Countdown 2015, Europe has provided strong support for family planning in some of the dark days. If their figures are right, 500 million Euros have been raised for family planning and reproductive health.

I see several other important trends at this meeting. First, for a long time our community has been fragmented. The MDG framework has helped to pull us together. But I can see now that we’re all in this together. Those who believe the population factor is critical to development and those who believe in comprehensive reproductive and sexual rights – we all belong to one community. Another trend is calling for more funding for family planning. If we do increase resources, if the U.S. Government allocates the most family planning funding in history, is this going to solve the issue? Are we going to reach MDGs because of this? No, not if resources are not well spent. The family planning community has the right and the responsibility to be watchdogs. You should criticize the donors and speak up if you think we are not spending our money correctly in terms of achieving the MDGs.

The biggest threat to the family planning community is if the South does not own this issue. If we don’t empower voices of men, women and children from the South, then we will fail, because that’s where the action is.

Question #2:

What are your observations concerning financing MDG-5b (universal access to contraception)? How much money do we need? Are country governments asking specifically for MDG-5b, and are donors responding? With the opportunities for more resources, how do we address “more money, better spent?”

Dr. Scott Radloff, USAID:

How much money is needed varies country by country. Back in 2003, UNFPA and Guttmacher provided a summary of the costs required. This report was called “Adding it Up,” and it is being updated now. As of 2003, $3.9 billion was needed to address unmet need in developing countries. Worldwide, there were 500 million contraceptive users but 200 million more with unmet contraceptive need, so there were two users for every woman with unmet need. In Africa, however, this ratio is reversed. For each woman using
contraception, two or three others have unmet contraceptive need. This suggests that we need two or three times as much investment in Africa as in other regions of the world.

Modern contraceptive use has been increasing in sub-Saharan Africa at a rate of 1/2 of a percentage point per year, but we still see, on average, 25 – 30% unmet need. At the rate we are going, it will take 50-60 years to address unmet contraceptive need in Africa. USAID has been shifting resources from Latin America and Eastern Europe to focus on sub-Saharan Africa and Southeast Asia. We have doubled the resources going to sub-Saharan Africa. There have been recent successes in contraceptive prevalence increases – Ethiopia, Kenya and Rwanda. Contraceptive prevalence is also increasing in Tanzania and Uganda, but not as dramatically.

Funding is urgently needed to help avoid contraceptive shortfalls. The price of success is a bigger bill for contraceptive supplies. USAID is working with UNFPA and other donor partners to coordinate contraceptive shipments and planning, but there are still crises.

Population growth also drives contraceptive costs up. There was a stall in the contraceptive prevalence in Kenya between 1995 and 2005. Compared to 1985 when Kenya’s success story began, the number of women of reproductive age has doubled. We now need twice the resources to achieve similar levels of progress. For this reason, it is also important that national governments are invested.

Based on Khama Rogo’s speech, I would like to frame some key recommendations for the way forward. First, we need better strategies for reaching the poor. Unmet need is higher among poor, rural women in sub-Saharan Africa. For example, we need to follow the progress others have made in terms of community-based delivery of injectables. Second, we need to focus on private sector development and increasing access to private sector services. Wealthier, more urban persons can then rely on the private sector while the government takes care of the poor. Third, we should continue to use social marketing and public-private partnerships to expand community-based contraceptive services. Last, we need to advocate for the commitment of national governments to make family planning a priority. Even with more global resources, the success of family planning programs depends on local government commitment.

Mr. Anthony Daly, DFID:

Family planning has decreased 34% over the past 10 years. As a proportion of global health funding, it has decreased from 55% to 5%, largely because it is being crowded out by AIDS. We need at least 10% of health funding going to reproductive health. At the UN General Assembly, more than $5 billion in new funding was dedicated to reproductive health. The G8 also gave a strong commitment, and the G8 should be held accountable. However, we also need non-traditional sources of financing for reproductive health. For example, 37 countries raised population as a serious issue in conjunction with climate change.

We need strong countries to lead by example in devoting funding to reproductive health. DFID is now decentralized, so much more is left up to the countries. We have committed 100 million pounds to UNFPA for filling family planning gaps.

During the session this morning, we talked about integration and harmonization. The audience indicated that it was committed to harmonization. Part of this involves lowering our flags and being flexible with the use of branding. For example, we need to be comfortable printing the logos of our partners.

We also need to hold development partners accountable and continue the emphasis on advocacy. We need to strategize about incentives for integration. If I am managing a vaccination program and have to stretch resources to do my own work, I have no incentive to add family planning. Regular peer review can help us to better integrate and harmonize our work.
Dr. Sadia Chowdhury, World Bank:

This is a time of opportunity. We are finally talking about family planning as a large-scale issue. However, there are also other opportunities. Our main objective is to understand what is required to reach MDGs in 48 countries? How do we raise the money that is required? Resources are finite. One recommendation for taking services to scale would require $11 billion. There is momentum, but resources are required.

Integrating programs through health systems strengthening is also important. It is not enough to say we will do it, but we have to figure out the best way to link programs. Harmonization among donors is finally happening. People are leaning toward one national health plan, one M&E system and one financing system. Above all, the country has to be in charge. This is the “how to” harmonization when the rubber hits the road. Global partners have also realized we have to come together and give one message. We have to take advantage of this time. Otherwise, it will be no one’s fault but our own.

The World Bank has been supporting family planning since 1969. We began moving into comprehensive reproductive health programs after IPCD. The Bank had a definitive profile in reproductive health with stand-alone programs, but the reproductive health focus was not as prominent after we moved into sector wide work like poverty reduction. However, the Bank’s funding for reproductive health is at the highest level ever. We are now working on how to strengthen programs in 58 high fertility countries. We were mandated by the World Bank board to write an action plan, and it is in draft form now. We will be focusing on unintended pregnancy, STI management and other issues. This report will be presented to the Bank board in March 2010.

The Bank can best contribute by encouraging integration and harmonization among its partners, including leverage more funding, and working in health systems strengthening in countries. We will also continue to conduct high-level policy dialogue and help develop strategies for country-level assistance. In doing this, we must work multi-sectorally in areas such as transportation, gender and the environment.

I will leave you with one word of caution. We are all believers. We need to engage in dialogue with Ministers of Finance and Planning, and we should use their language to explain why they should invest in family planning. Go back and face the non-believers.

18 NOVEMBER 2009 – CLOSING PLENARY

Not recorded.