Conference Program and Abstracts

INTERNATIONAL CONFERENCE ON FAMILY PLANNING RESEARCH AND BEST PRACTICES

Munyonyo, Uganda | November 15 – 18, 2009

www.fpconference2009.org
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Bayer Schering Pharma
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WELCOME!

Over the coming days, you and more than 1000 other conferees, representing 59 countries and hailing from Afghanistan to Zambia, will advance the field of family planning at the first international conference solely dedicated to research and best practices. The Conference co-sponsors and many supporting partners and colleagues are excited and look forward to your contributions here and after the meeting.

We are grateful to the First Lady and other senior government officials for opening the Conference and to the people of Uganda for their hospitality. We also thank the many other distinguished guests and senior delegates for their time and effort to participate at this Conference. Among us are policy makers, program directors, parliamentarians, researchers, clinicians, academicians, journalists, lawyers, students, trainers, journalists, health professionals, international donor and foundation staff, and leaders of faith-based organizations, pharmaceutical companies, communities and businesses from around the world. The national and international steering committees for this Conference have assembled a diverse and stimulating program of the latest scientific findings, transformative knowledge and updated skills that together can advance access to family planning and make it universal by 2015.

The program for the next four days has no less than 67 technical sessions, which include over 400 oral and poster presentations, 95 luncheon topical roundtables, 30 professional exhibitors and 25 auxiliary workshops. The program on November 18 is focused on translating “Knowledge into Action” and has been organized by the Implementing Best Practices Initiative.

The Reaffirmation of Global Family Planning Commitments will be released during the Conference to remind us of past global statements and unfulfilled vows to assure access to family planning. It is our firm belief that unlike any previous gathering, this community of like-minded conferees can make this goal happen now and universally.

Again, many thanks for lending your expertise to the conference and again, welcome!

The Sponsors and Organizers of the 2009 International Family Planning Conference
PROGRAM AT-A-GLANCE
Changes will be displayed outside the conference office.

Sunday, 15 November 2009

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<td>Chair: David Serwadda, Makerere University, School of Public Health</td>
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<td></td>
<td>Family Planning: From Concept to Consolidation, Amy Tsui, JHU</td>
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<td>Research Needs for Contraceptive Technology Development, Laneta Dorflinger, FHI</td>
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<td>Integrating HIV and Family Planning Services: Evidence at Hand, Evidence Needed, Michael Mbizvo, WHO</td>
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<td>Estimating Family Planning Costs to Meet MDG 5b, Stan Bernstein, UNFPA</td>
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<td>9:30am</td>
<td>A01: Family Planning and the MDGs</td>
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<td>Chair: Hasan Mohotashami</td>
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<td>9:30am</td>
<td>B01: Measuring and Responding to Unmet Need</td>
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<td>D01: Integrating Family Planning and HIV Programs I</td>
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<td>B02: Contraceptive Use: Levels and Trends</td>
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<td>C02: Psycho-social Aspects of Family Planning</td>
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<td>F02: Promoting Family Planning through Digital, Mobile and Wireless</td>
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<td>G06: Emergency Contraception: Prospects and Practice</td>
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<td>C07: Family Planning Financing</td>
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<td><strong>Location:</strong> Albert Hall</td>
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<td><strong>Chair:</strong> Alexandra Todd-Linkopp</td>
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<td><strong>Chair:</strong> Laura Ackah</td>
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<tr>
<td>3:30pm</td>
<td>D07: Addressing the Family Planning Needs of People Living with HIV I</td>
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<td><strong>Location:</strong> Victoria Ballroom</td>
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<td></td>
<td><strong>Chair:</strong> Julianna Lunguz</td>
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<td><strong>Chair:</strong> Dana Dakan</td>
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<tr>
<td>3:30pm</td>
<td>E07: Matching Family Planning/RH Services to Unmet Needs</td>
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<td><strong>Location:</strong> Regal Hall</td>
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<td><strong>Sponsor:</strong> Jhpiego</td>
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<tr>
<td>4:00pm</td>
<td>F07: Service Delivery for Injectable, Implants, and Oral Contraception</td>
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<td><strong>Location:</strong> New Hall #1</td>
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<td></td>
<td><strong>Chair:</strong> Angela Akol</td>
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<td></td>
<td><strong>Chair:</strong> Sheila Nyawira Macharia</td>
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<tr>
<td>4:00pm</td>
<td>G07: Service Provision Assessments to Strengthen Family Planning Programs</td>
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<td><strong>Location:</strong> New Hall #2</td>
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<td><strong>Sponsor:</strong> Macro International</td>
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<tr>
<td>3:30pm</td>
<td>P4: Poster Session 4: Contraceptive Technology, Financing and Reproductive Health Issues</td>
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<td></td>
<td><strong>Location:</strong> Pre-Conference Area</td>
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<tr>
<td>4:00pm</td>
<td>A08: National Family Planning Policy and Advocacy II</td>
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<td></td>
<td><strong>Location:</strong> Sheena Hall</td>
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<td></td>
<td><strong>Chair:</strong> Harry Jooosey</td>
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<td><strong>Chair:</strong> Anthony Mboneye</td>
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<tr>
<td>5:30pm</td>
<td>B08: Operations Research on Postpartum Family Planning</td>
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<tr>
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<td><strong>Location:</strong> Meera Hall</td>
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<td><strong>Sponsor:</strong> Population Council</td>
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<tr>
<td>4:00pm</td>
<td>C08: Public-Private Partnerships for Successful Family Planning Financing</td>
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<td><strong>Location:</strong> Albert Hall</td>
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<td></td>
<td><strong>Chair:</strong> Paul Hamilton</td>
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<td><strong>Chair:</strong> Phil Harvey</td>
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<tr>
<td>5:30pm</td>
<td>D08: Addressing the Family Planning Needs of People Living with HIV II</td>
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<td><strong>Location:</strong> Victoria Ballroom</td>
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<td><strong>Chair:</strong> Alice Auma Olawo</td>
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<tr>
<td>3:30pm</td>
<td>E08: Contraceptive Failure, Unwanted Pregnancy and EC</td>
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<td><strong>Sponsor:</strong> INED</td>
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<tr>
<td>4:00pm</td>
<td>F08: Harnessing Social Institutions to Support Family Planning</td>
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<td><strong>Location:</strong> New Hall #1</td>
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<td><strong>Chair:</strong> John Cleland</td>
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<td><strong>Chair:</strong> Linda Cahaele</td>
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<tr>
<td>5:30pm</td>
<td>G08: Effective Programming and Service Delivery III</td>
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<td></td>
<td><strong>Location:</strong> New Hall #2</td>
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<tr>
<td></td>
<td><strong>Chair:</strong> Beatrice Atieno Ochieng</td>
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# Wednesday, 18 November 2009

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>8:30am - 10:30am</td>
<td>Plenary, Victoria Ballroom</td>
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<tr>
<td></td>
<td>Summary of the First Two Days of the Family Planning Conference, Ward Cates, President, Family Health International</td>
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<tr>
<td></td>
<td>IBP Principles and Practice, and Country Experience, Josephine Kibaru, Head Division of Reproductive Health, Ministry of Health Kenya</td>
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<tr>
<td></td>
<td>How Change Agents Make a Difference, TBD</td>
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<td>New Technologies for Family Planning Advocacy, Jotham Musinguzi, Director, Partners in Population and Development, Africa Regional Office</td>
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<tr>
<td>10:30am - 11:45am</td>
<td>A09: Mobilizing Commitment and Funding for Family Planning</td>
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<td>Location: Sheena Hall</td>
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<td>Chair: Pape A Gaye</td>
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<td>B09: Leading and Managing for Results in Family Planning</td>
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<td>Location: Meera Hall</td>
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<td></td>
<td>Chair: Timothy Allen</td>
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<td>C09: Access to RH Essential Medicines and Commodities:</td>
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<td>The Missing Link to Improving RH</td>
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<td>Chair: Maggie Usher-Patel</td>
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<td></td>
<td>D09: Promoting Access and Affordability of Family Planning</td>
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<td>Chair: Angela Akol</td>
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<tr>
<td>11:45am - 1:00pm</td>
<td>E09: Working Together to Integrate Family Planning into Other Essential Services</td>
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<td>Chair: Mario Festin</td>
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<td>F09: Preparing the Next Generation of Family Planning Providers</td>
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<td>Chair: Rosemary Kamunya</td>
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<tr>
<td>1:00pm - 2:00pm</td>
<td>A10: Improving Family Planning Through Communication and Client Centered Care</td>
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<td>Chair: Gulen Arzum Ciloglu</td>
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<td>B10: Partnerships: A Powerful Force for Change</td>
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<td>Chair: Suzanne Reier</td>
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<td>C10: Innovations in Knowledge Sharing and Networking for Family Planning</td>
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<td>Chair: Angela Nash-Mercado</td>
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<td></td>
<td>D10: Gender and Reproductive Rights: The Foundation of Successful Family Planning Programmes</td>
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<td>Chair: Janet Jackson</td>
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<td>2:00pm - 3:30pm</td>
<td>E10: Health Systems Strengthening: What to Target for Sustainable, Quality Family Planning Services</td>
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<td>Chair: Eduard Bos</td>
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<td>F10: Addressing Youth Special Needs: Lessons Learned from Research</td>
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<td>Location: New Hall #2</td>
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<td>Chair: Laura Laski</td>
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<tr>
<td>3:30pm - 5:00pm</td>
<td>CB01: The Missing Link: The Management of Change to Scale Up Effective Practices</td>
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<td>CB02: Using Family Planning Tools: WHO Guidance and Provider Checklists</td>
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<td>CB03: Scaling Up From the Start: Beginning with the End in Mind</td>
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<td>CB04: Reality Check: A Forecasting Tool for Evidence-Based Planning and Advocacy</td>
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<td>CB05: Tips and Tools for Family Planning Advocacy</td>
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<td>CB06: Documentation of &quot;Practices that Make Programmes Work&quot;</td>
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<td>CB07: &quot;Social Analysis and Action” Approach</td>
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<td>CB08: Improving Technical Assistance with a Focus on Evidence-Based Practices</td>
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<td>CB09: Female Condom Programming</td>
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<td>Location: Majestic Hall</td>
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<tr>
<td>4:00pm - 5:00pm</td>
<td>Plenary: Donor Panel, Victoria Ballroom</td>
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<td>Chair: Jotham Musinguzi</td>
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<td>Partners in Population and Development/Africa Regional Office</td>
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<td>US Agency for International Development</td>
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<td>Dr. Scott Radloff</td>
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<td>Bill and Melinda Gates Foundation</td>
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<td>Mr. Jose Rimon</td>
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<td>World Bank</td>
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<td>Dr. Sadia Chowdhury</td>
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<td>United Nations Population Fund</td>
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<td>Mr. Jagdish Upadhyay</td>
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<tr>
<td>5:00pm - 6:00pm</td>
<td>Closing Plenary, Victoria Ballroom</td>
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<td>(see agenda on page 17)</td>
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</tbody>
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Dr. Linda Kalilani, College of Medicine, University of Malawi, Malawi
Ms. Sabrina Karklins, Johns Hopkins Bloomberg School of Public Health, United States
Dr. Rita Khamzayeva, United Nations Population Fund (UNFPA), United States
Dr. Suzanne Kiwanuka, Makerere University School of Public Health, Uganda
Ms. Louise Lee-Jones, Marie Stopes International, United Kingdom
Dr. Susan M. Lee-Rife, International Center for Research on Women, United States
Dr. Li Liu, Census Bureau/Sabre Systems, Inc., United States
Ms. Liliane Christine Luwaga, Ministry of Health, Uganda
Dr. Ron Magarick, Jhpiego, United States
Dr. Kuhu Maitra, Abt Associates Inc., United States
Dr. Fredrick E Makumbi, Makerere University School of Public Health, Uganda
Dr. John May, World Bank, United States
Ms. Blessing Mberu, Africa Population and Health Research Center (APHRC), Kenya
Dr. Catharine McKaig, Jhpiego, United States
Dr. Yilma Melkamu, International Planned Parenthood Federation, United States
Ms. Alice Payne Merritt, Johns Hopkins Bloomberg School of Public Health, United States
Dr. Ann Moore, Guttmacher Institute, United States
Ms. Carie Jean Muntifering, Johns Hopkins Bloomberg School of Public Health, United States
Mr. Ye Mon Myint, Johns Hopkins Bloomberg School of Public Health, United States
Dr. Wilfred David Ochan, UNFPA, Uganda
Dr. Peter Olasupo Ogunjuyigbe, Obafemi Awolowo University, Ile-Ife, Nigeria, Nigeria
Dr. Ebenezer Ojoletiimi, Obafemi Awolowo University, Ile-Ife, Nigeria, Nigeria
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Ms. Sara Louise Sulzbach, Abt Associates, Inc., United States
Ms. Alexandra Ruth Todd-Lippock, USAID, United States
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Dr. Jianhua Yang, Johns Hopkins Bloomberg School of Public Health, China
Dr. Laurie Zabin, Johns Hopkins Bloomberg School of Public Health, United States
Dr. Eliya Zulu, Africa Population and Health Research Center (APHRC), Kenya
ACKNOWLEDGEMENTS

Bill and Melinda Gates Institute for Population and Reproductive Health
Sarah Bottomley
Natalie Culbertson
Carrileen Edwards
Maura Graff
Monnie Heminthavong
Sabrina Karklins
Faraz Naqvi
Denise Nowlin
Sarah Preston
Amy Tsui

Johns Hopkins Bloomberg School of Public Health
Duff Gillespie
Christine Grillo
Michael Klag
Henry Mosley
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Laurie Zabin

Makerere University, School of Public Health
William Bazeyo
Fred Makumbi
Susan Makwembo
Angela Nanyanzi
Elizabeth Niambi
Christopher Orach
David Serwadda

Partners in Population and Development
Charity Birungi
Noah Kiwanuka
Abdelyah Lakssir
Patrick Mugirwa
Jotham Musinguzi
Robinah Najemba
Diana Nambatya
Nichele Zlatunich

United States Agency for International Development
Carmen Coles
Alexandra Todd-Lippock
Scott Radloff

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Tim Allen, MSH
Hannah Burris, FHI
Eva Canoutas, FHI
Arzum Ciloglu, CARE
Issakha Diallo, MSH
Joseph Dwyer, MSH
Mario Festin, WHO
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Mona Kaidbey, UNFPA
Jan Kumar, EngenderHealth
Catherine McKaig, Jhpiego
Angela Nash-Mercado, Jhpiego
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Nuriye Orayli, UNFPA
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Catherine Richey, WHO
Jason Smith, FHI
Cathy Solter, Pathfinder
Holley Stewart, Africa’s Health in 2015
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Esther Tahrir, PHI
Nandita Thatte, USAID
Maggie Usher-Patel, WHO

Rapporteurs
Michael Adrawa, Makerere University SPH
Peninah Agaba, Makerere University, Population Studies
Ann Bagenda, Makerere University SPH
Sarah Bottomley, Johns Hopkins Bloomberg SPH
Heather Bradly, Johns Hopkins Bloomberg SPH
Kate Cho, Family Health International
Gilbert Habaasa, Makerere University SPH
Anwar Kakeeto, Makerere University SPH
Amos Laar, University of Ghana SPH
Dana Loll, Johns Hopkins Bloomberg SPH
Carie Muntifering, Johns Hopkins Bloomberg SPH
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Denis Nuwagaba, Uganda Martyrs University
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Barbara Okot, Makerere University SPH
Chelsea Polis, Johns Hopkins Bloomberg SPH
Jackson Sekikubo, Makerere University SPH
Patrick Thiwe Okumu, Makerere University SPH
Photography/Videography
James Blue
Dave Colwell
Sebastian Rich

Quality Management Services, Uganda
Rachel Lubega
Mary Nakivumbi
Margaret Nansamba
Jackie Nansumbuga

Broad Street Pump Graphics, Baltimore
Jaclyn Cohen
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Other Supporters
Angela Akol
Abeja Apunyo
Dorothy Balaba
Sahlu Haile
Barbara Katende
Betty Kayaddondo
Lillian Luwaga
Prabhat Mishra
Hassan Mohtashami
## EXHIBITORS

**Abt Associates**  
Sara Sulzbach  
Sara_Sulzbach@abtassoc.com

**Bayer/Surghipharm**  
Mr. Mugwanya  
mugmox@yahoo.com

**DKT Egypt**  
Danna E. Gobel  
dgobel@dktegypt.com

**EngenderHealth**  
Carrie Meyers  
cmeyers@engenderhealth.org

**Family Health International**  
Hannah Burris  
hburris@fhi.org

**Futures Group**  
Anita Bhuyan  
abhuyan@futuresgroup.com

**Health Communication Partnership**  
Barbara Katende  
barbarak@hcpuganda.org

**WHO/RHR and Implementing Best Practices (IBP) Initiative**  
Suzanne Reier  
reiers@who.int

**Institute for Reproductive Health-Georgetown**  
Dina Abi Rached  
d.abirached@gmail.com

**International Center for Research on Women**  
Susan Lee-Rife  
sleerife@icrw.org

**Jhpiego**  
Mary Kay Carver  
mcarver@jhpiego.net

**Johns Hopkins Bloomberg School of Public Health Center for Communication Programs**  
Megan O’Brien  
mlobrien@jhuccp.org

**Management Sciences for Health**  
Lara Sider Jost  
lsider@msh.org

**Marie Stopes International**  
Louise Lee-Jones  
louise.lee-jones@mariestopes.org.uk

**PACE**  
Monica Ariyo  
mariyo@pace.org.ug

**Partners in Population and Development**  
Charity Birungi  
cbirungi@ppdsec.org

**Pathfinder International**  
Kali Drake, KDrake@pathfind.org  
Mayra Nicola, MNicola@pathfind.org

**Population Council**  
Monica Wanjiru  
mwanjiru@popcouncil.org

**Population Reference Bureau**  
Jay Gribble  
jgribble@prb.org

**Population Services International**  
Corina Clement  
cclemente@psi.org

**Population Secretariat**  
Barbara Kyomugisha  
kennykyomu@yahoo.com

**Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative**  
Heilbrunn, Janet Butler-McPhee  
jb2779@columbia.edu

**Reproductive Health Uganda**  
Martha Songa  
msonga@rhu.or.ug

**USAID**  
Carmen Coles  
ccoles@usaid.gov
AUXILIARY MEETINGS AND WORKSHOPS
See page 339 for descriptions

Saturday, 14 November 2009

9:00am-5:00pm, Majestic Hall
Bringing New People to Family Planning: Fertility Awareness Methods Workshop for Trainers
Institute for Reproductive Health, Georgetown University
Contact: Ms. Dina Abi-Rached, da262@georgetown.edu

Sunday, 15 November 2009

10:00am-4:00pm, Emerald Hall
Building African Leadership on Population and Climate Change
Population Reference Bureau
Contact: Jason Bremner, jbremner@prb.org
By Invitation Only

10:00am-12:00pm, Room TBD
Sharing the Results of the Study of the Implementation of the Maputo Plan of Action (MPOA) in Africa - Level of the Implementation of MPOA
International Planned Federation Africa Regional Office
Contact: Cheick Ouedraogo, couedraogo@ippfar.org

1:00pm-3:00pm, Room TBD
Launch of the Women Leaders Initiative
International Planned Federation Africa Regional Office
Contact: Josephine Mutingi, jmutingi@ippfar.org

Monday, 16 November 2009

8:30am-5:30pm, Commonwealth Banqueting Hall
Financing Health-related Millennium Development Goals: Challenges and Opportunities
Contact: Jotham Musinguzi, jmusinguzi@ppdsec.org
Closed meeting, by invitation only

6:00-7:00pm, Stables Restaurant
Marie Stopes International Cocktail Event
Marie Stopes International will host a cocktail event. Dana Hovig (CEO) will launch the MSI calculator to measure the impact of family planning programmes.

7:00pm, Majestic Hall
Costing for Scale Up: A Skills-Building Workshop
Family Health International
Contact: Kate H. Rademacher, krademacher@fhi.org
7:00-8:30pm, Albert Hall
Maximizing the Contribution of Family Planning through the First Year Postpartum
Jhpiego
Contact: Angela Nash-Mercado, anash-mercado@jhpiego.net

7:00-8:30pm, Sheena Hall
Female Condom Programming: Breaking Down the Barriers!
Universal Access to Female Condoms' UAFC Joint Programme
Contact: Ilze Smit, i.smit@wpf.org

7:00-9:00pm, Meera Hall
Developing Cost-Effective Interventions to Increase Modern Contraceptive Use: Insights and Challenges from Nigeria and India
African Population and Health Research Center
Contact: Jean Christophe Fotso, jcfotso@aphrc.org

7:00-9:00pm, New Hall 1
Leaping the Hurdles and Navigating the Maze: Getting Funding from NIH
US National Institutes of Health, Center for Population Research
Contact: Susan Newcomer, newcomes@mail.nih.gov

7:00-9:00pm, New Hall 2
Stronger Health Systems for Family Planning
Management Sciences for Health
Contact: Laura Sider-Jost, lsider@msh.org

Tuesday, 17 November 2009

6:30-8:30pm, Meera Hall
How to Expand Community-Based Access to Injectable Contraceptives: Tools for Program Managers
Family Health International
Contact: Morrisa Malkin, MMalkin@fhi.org

7:00-9:00pm, Victoria Ballroom
IBP Technology Café
World Health Organization, Implementing Best Practices Initiative
Contact: Maura Graff, mgraff@jhsph.edu

7:00-9:00pm, Majestic Hall
From Family Planning Research to Public Policies in Africa: Strategic Campaign Imperatives
African Population and Health Research Center
Contact: Charles Okigbo, cokigbo@aphrc.org

7:00-8:30pm, Regal Hall
Models for Policy and Advocacy
Futures Group International
Contact: Suneeta Sharma, ssharma@futuresgroup.com

7:00-10:00pm, Albert Hall
Community and Social Change in Adolescent Sexual and Reproductive Health and Family Planning Programs: Strategies for Measuring Change
International Youth Working Group: Pathfinder International, CARE, Jhpiego, UNFPA, Georgetown University/ Institute for Reproductive Health
Contacts: Cate Lane, Pathfinder International, clane@pathfind.org; Susan Igras, GU/IRH, Smi6@georgetown.edu
International Conference on Family Planning: Research and Best Practices

7:00-9:00pm, New Hall 1
Round-Table Discussion about the Role and Expansion of Menstrual Regulation
Venture Strategies for Health and Development
Contact: Nadia Diamond-Smith, ndiamondsmith@venturestrategies.org

7:30-9:00pm, New Hall #2
Population and Reproductive Health at the World Bank: 2010-2015
World Bank
Contact: Seemeen Saadat, ssaadat@worldbank.org

Wednesday, 18 November 2009

10:00am-12:00pm, Regal Hall
STEPS: Steps to Transforming Evaluation Practice for Social Change Workshop
Margaret Sanger Center, International Planned Parenthood, New York City
Contact: Jacqueline Hart, Jacqueline.Hart@ppnyc.org

11:00am-1:00pm, Majestic Hall
Expanding What We Know about Abortion and Contraceptive Use: A Workshop on an Innovative Survey Methodology
International Center for Research on Women
Contact: Susan Lee-Rife, sleerife@icrw.org
Advanced registration required; if space available, onsite registration accepted

Thursday, 19 November 2009

8:15am-5:15pm, New Hall 2, 3, 4
Practicum on Family Planning Communication and Advocacy Responses in Africa
AfriComNet
Contact person: Charles Kakaire, ckakaire@africomnet.org
Advanced registration required (max 80 participants)

9:00am-5:00pm, Sheena Hall
Sexual and Reproductive Health Advocacy and Research: Best Practices and Partnerships Meeting
Population Action International
Contacts:
Suzanne Ehlers, sehlers@popact.org; Holly Greb, HGreb@popact.org
By invitation only

9:00am-1:00pm, Majestic Hall
An Orientation to Modern, Fertility Awareness-Based Methods: What Every Family Planning Program Manager Needs to Know
Institute for Reproductive Health, Georgetown University
Contact: Susana Mendoza Birdsong, smm56@georgetown.edu

9:00am-12:00pm (Room TBD)
How to Conduct High Impact Family Planning Research
MEASURE Evaluation
Contact: Scott Moreland, smoreland@futuresgroup.com
OPENING PLENARY

Sunday, 15 November 2009, 4:00-6:30pm, Victoria Ballroom

Moderator and Master of Ceremonies: Dr. William Bazeyo, Dean, Makerere University School of Public Health

<table>
<thead>
<tr>
<th>Time</th>
<th>Program event</th>
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<tbody>
<tr>
<td>3:00pm</td>
<td>Ballroom doors open</td>
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<tr>
<td>4:00pm</td>
<td>Call to Order</td>
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<td></td>
<td>Arrival of the First Lady of Uganda</td>
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<td>National Anthem</td>
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<td>Welcome on behalf of</td>
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<td>National Steering Committee – Dean William Bazeyo, Makerere University, School of Public Health</td>
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<td>International Steering Committee – Dean Michael Klag, Johns Hopkins Bloomberg School of Public Health</td>
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<td>4:30pm</td>
<td>Goodwill Messages from Local Community and International Supporters</td>
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<td>Voices from the Community – Fatima and Zubairu Muwesi</td>
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<td>United Nations Population Fund – Dr. Werner Haug</td>
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<td>World Bank – Dr. Sadia Chowdhury</td>
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<td>World Health Organization – Dr. Michael Mbizvo</td>
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<td>USAID – Dr. Scott Radloff</td>
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<td>Bill &amp; Melinda Gates Foundation – William H. Gates Sr. (video) and Mr. Jose (Oying) Rimon II</td>
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<td>5:30pm</td>
<td>Welcome remarks and Introductions</td>
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<td>Minister of Health – Hon. Dr. Stephen Mallinga</td>
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<td>African Union – HE Commissioner Bience Gawanas</td>
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<td>6:00pm</td>
<td>Keynote address – Her Excellency, Mrs. Janet Museveni, First Lady of Uganda</td>
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<td>Dinner Reception (poolside)</td>
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<td>Cultural Entertainment</td>
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## CLOSING PLENARY

**Wednesday, 18 November 2009, 4:00-6:00pm, Victoria Ballroom**

Moderator and Master of Ceremonies: Dr. Jotham Musinguzi, Partners in Population and Development

<table>
<thead>
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<th>Time</th>
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<tr>
<td><strong>4:00pm</strong></td>
<td><strong>Advancing Family Planning: Donors, Governments and Civil Society</strong></td>
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<td>US Agency for International Development – Dr. Scott Radloff</td>
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<td>Bill and Melinda Gates Foundation – Mr. Jose (Oying) Rimon II</td>
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<td>World Bank – Dr. Sadia Chowdhury</td>
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<td>United Nations Population Fund – Mr. Jagdish Upadhyay</td>
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<td>United Kingdom Department of International Development - TBD</td>
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<td>Audience Q&amp;A</td>
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<td><strong>5:00pm</strong></td>
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<td>Best Research Presentation by Young Investigator</td>
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<td>Voices from the Community – Fatima and Zubairu Muwesi</td>
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<td>Re-Affirmation of Global Commitments to Family Planning</td>
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<td>Remarks from UNFPA Africa Regional Office – Dr. Bunmi Makinwa</td>
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<td>Remarks from Uganda’s Minister of Health – Hon. Stephen Mallinga</td>
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<td>Vote of thanks – Representatives of Makerere and Johns Hopkins Universities’</td>
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<td>Schools of Public Health</td>
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<td><strong>6:00pm</strong></td>
<td>Adjourn</td>
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PROGRAM SUMMARY

Monday, 16 November 2009

PLENARY

Time: Monday, 16 November 2009: 8:30am - 9:30am  
Location: Victoria Hall

Session Chair: David Serwadda, Makerere University, School of Public Health

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

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

Integrating HIV and FP Services: Evidence at Hand, Evidence Needed
Michael Mbizvo, World Health Organization

Estimating Family Planning Costs to Meet MDG 5b
Stan Bernstein, United Nations Population Fund

A01: FP and the MDGs

Time: Monday, 16 November 2009: 9:30am - 11:00am  
Location: Sheena Hall

Session Chair: Hasaan Mohtashami

Session Chair: Malcolm Potts

A01: 1
Achieving the Millennium Development Goals: The Contribution of Family Planning
Rachel Sanders, Scott Moreland, Thomas Goliber
Futures Group, United States of America; rsanders@futuresgroup.com

A01: 2
Prerequisites to meet Family Planning Unmet Needs in Sub-Saharan Africa
Jean-Pierre François Guengant1, John F. May2
1Institut de Recherche pour le Développement, Burkina Faso; 2The World Bank Africa Region, AFTH2; guengant@ird.bf

A01: 3
Contraceptive use in urban sub-Saharan Africa: Recent trends and differentials set in the policy and program context
Jean Christophe Fotso3, Ilene Speizer4, David Guilkey5, Gwen Morgan6
3African Population and Health Research Center (APHRC), Kenya; 4University of North Carolina at Chapel Hill (UNC), USA; jcfotso@aphrc.org

A01: 4
Promoting family planning within the context of environmental management yields higher MDG achievement: Evidence from the Philippines
Joan Regina Luponon Castro7, Leona Ann D’Agnes8
7PATH Foundation Philippines Inc, Philippines; 8PATH Foundation Philippines Inc, Philippines; jcastro@pfpi.org

B01: Measuring and Responding to Unmet Need

Time: Monday, 16 November 2009: 9:30am - 11:00am  
Location: Meera Hall

Session Chair: Christopher Garimo Orach

Session Chair: W. Henry Mosley

B01: 1
When One Size Doesn’t Fit All: Using Client-Centered Market Segmentation Analysis to Tailor Family Planning Interventions in the Philippines
Wenjuan Wang, Rebecca Patsika, Ruth Berg, Sara Sulzbach
Abt Associates Inc., United States of America; wenjuan_wang@abtassoc.com

B01: 2
Understanding unmet need: Changes in measurement over time in the Demographic and Health Surveys
Sarah E.K. Bradley, Joy Fishel, Trevor Croft
ICF Macro, United States of America; sarah.e Bradley@macrointernational.com

B01: 3
Building a balanced method mix: The potential sustainability of low-cost implants in family planning programs
Katherine Tumlinson1, Alice Olwo2, Marsden Solomon2, Markus Steiner2
1Family Health International, United States of America; 2Family Health International, Kenya; ktumlinson@fhi.org

B01: 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.

Sikola Z Wanyonyi,1, Evan Sequeira,1, Yeri Kombe2
1Aga Khan University Hospital, Kenya; 2CPHC; Kenya Medical Research Institute, Kenya; sikolaw@gmail.com

D01: 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

Getu Dego Alene1, Alemayehu Worku2
1University of Gondar, Ethiopia; 2Addis Ababa University, Ethiopia; adgetu123@yahoo.com

C01: FP for Vulnerable Populations

Time: Monday, 16 November 2009: 9:30am - 11:00am
Location: New Hall #1

Session Chair: Richard Kawooya
Session Chair: Shelley Snyder

C01: 1
Innovative effective approaches for increasing family planning access in difficult to access settings

Molly Louise Fitzgerald1, Othello James2, Clarence Massaquoi3, Daniel Dalton4, Florence Davis5
1JSI Research&Training Astarte Project; United States of America; 2Children Smile Humanitarian Network, Liberia; 3PMU-Liberia; 4Paracom-Liberia; 5Merci-Liberia; mf Fitzgerald@jsi.com

C01: 2
Targeting public sector resources and efforts to improve access to FP services among the Poor in Peru

Suneeta Sharma, Gracia Subiria
Futures Group International, United States of America; ssharma@futuresgroup.com

C01: 3
Family Planning as a Basic Life-Saving Skill: Lessons from Africare’s Program in Rural Liberia

Rachel Louise Criswell, Marieta Yeke, Claudette Bailey
Africare-Liberia; rachelcriswell@gmail.com

C01: 4
Reproductive Health Commodity Security in post-conflict situations, a case of northern Uganda

Sarah Mbabazi, Dorothy Balaba
Program for Accessible Health, Communication and Education, Uganda; pace@pace.org.ug

D01: Integrating FP and HIV Programs I

Time: Monday, 16 November 2009: 9:30am - 11:00am
Location: Victoria Ballroom

Session Chair: Olive Sentumbwe Mugisa
Session Chair: Michael Strong

D01: 1
Integrating Family Planning (FP) services into HIV Counseling and Testing (HCT) services in DRC

Charly Mampuya1, M. Mpingulu2, J. Kibungu3, E. Engetele4, L. Maluantesa5, J. Kluba6, M.L. Mbo7, M. Mayala8
1Family Health International, Congo, Democratic Republic of the; 2CSR Mvuzi; 3HGR Kenya; 4PNSR; cmampuya@fhi.org

D01: 2
Strategies used facilities to integrate Family Planning into HIV Care: What works and what doesn’t

Ibrahim Kirunda1, Nigel Livesley2, Jacinto Amandua3, Zainab Akol4, Kenneth Kasule5
1University Research Co., LLC, Uganda; 2University Research Co., LLC, Uganda; 3Ministry of Health, Uganda; 4Ministry of Health, Uganda; 5University Research Co., LLC, Uganda; ikirunda@urc-chs.com

D01: 3
Integration of family planning services into community-based care for people living with HIV in Ethiopia

Medahnit Wube, Francesca Stuer
Family Health International, Ethiopia; mwube@fhi.org.et

D01: 4
Policy and Operational Barriers to Family Planning and HIV Integration in Kenya

Meghan Bishop, Beatrice Okundi, Carol Shepherd, Rachel Sanders
Futures Group International, United States of America; mbishop@futuresgroup.com

D01: 5
Without Strong Integration of Family Planning into PMTCT Services Clients Remain with a High Unmet Need for Effective Family Planning

Jennifer Asuka Leslie1, Emmanuel Munyamabanza2, Susan E. Adamchak3, Thomas W. Grey4, Kyampof Kirota5
1Family Health International/Rwanda Country Office; 2Family Health International/North Carolina; 3National AIDS Control Commission of Rwanda; aleslie@doctors.org.uk
E01: Contraceptive Technology I

**Time:** Monday, 16 November 2009: 9:30am - 11:00am  
**Location:** New Hall #2

**Session Chair:** Noah Kiwanuka  
**Session Chair:** Anne Burke

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**E01: 1**

**Quality Assurance Evaluation of Sino-implant (II): a low cost, safe and effective contraceptive implant**

David Jenkins, Aida M. Cancel, Markus Steiner  
Family Health International, United States of America; acancel@fhi.org

**E01: 2**

**Expanding Contraceptive Options in South Africa: Knowledge, Attitudes, and Practices Surrounding the Intrauterine Device**

Sarah A Gutti1, Chelsea Morroni1, Margaret Moss2, Regina Mlobe1  
1Women’s Health Research Unit, School of Public Health and Family Medicine, University of Cape Town; 2Department of Obstetrics and Gynecology, University of Cape Town; 3Department of Obstetrics, Gynecology and Reproductive Sciences, University of California San Francisco; sagutin@hotmail.com

**E01: 3**

**Feasibility of over-the-counter provision of the SILCS diaphragm: experience of women inserting and positioning the device after reading written instructions only in the pivotal trial**

Jill L Schwartz1, Maggie Kilbourne-Brook2, Ron G Frezieres3, Mitchell D Creinin4, David Archer5, Lynn Barnhart5, Kurt Barnhart6, Alfred Poindexter7, Christine Mauck1, Debra Weiner8, Marianne M Callahan9  
1CONRAD/Eastern Virginia Medical School, United States of America; 2PATH, United States; 3California Family Health Council, United States; 4University of Pittsburgh, United States; 5Johns Hopkins Medical Service Corporation, United States; 6University of Pennsylvania, United States; 7Advances in Health, United States; 8Family Health International, United States; jschwartz@conrad.org

**E01: 4**

**Development and Acceptability of the NES/EE CVR: A,Year-Long, User Controlled Contraceptive Method**

Ruth Merkatz, Regine Struk-Ware, Irving Sivin, Barbara Mensch, Paul Hewett, Michael Cooney, Elena Hoskin  
Population Council, Center for Biomedical Research, United States of America; rmerkatz@popcouncil.org

**E01: 5**

**Increasing access to injectable contraceptives: Introduction of depo-subQ provera 104™ in the Uniject® device**

Sara Jane Tiffy, Jane Hutchings  
PATH, United States of America; stifft@path.org

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F01: Effective Programming and Service Delivery

**Time:** Monday, 16 November 2009: 9:30am - 11:00am  
**Location:** Albert Hall

**Session Chair:** Henry Kakande  
**Session Chair:** Kathryn Panther

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**F01: 1**

**Client and Provider Perspectives on Barriers to Family Planning Quality in Kenya: Assessment and Programmatic Implications**

Constance Ambasa-Shimanyi1, C Homan2, J Alaii3, C Mackenzie3, B Kigen1, A Njeru1, C Mutunga2  
1Family Health International, Kenya; 2Division of Reproductive Health, Ministry of Health, Kenya; cambasa@fhi.org

**F01: 2**

**Evaluations of the impact of quality of care interventions on clients’ behaviors in three countries**

Ian David Askew  
Population Council, Kenya; iaskew@popcouncil.org

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**F01: 3**

**Impact of Exposure to Family Planning Interventions on use of Modern Family Planning Methods in Nigeria**

Samson Babatunde Adebayo, Richard Fakolade, Chinazo Ujuju, Jennifer Anyanti  
Society for Family Health, Nigeria; sadebayo@sfnigeria.org

**F01: 4**

**District Participation in the selection of Project target zones for delivering Family Planning Services in Uganda**

Elke Konings1, Paul Hamilton1, Henry Kakande1, A. SK Nabatanzi1, Anthony Mbonye2  
1Management Sciences for Health, Uganda; 2Ministry of Health, Uganda; ekonings@msh.org

**F01: 5**

**Increasing Couple Years of Protection (CYP): Successful Strategies from a Community-Based Family Planning Program in Uganda**

Heather Lukolyo, Paige Anderson Bowen, Pamela Mukaire, Laura C. Ehrlich, Diana K. DuBois  
Minnesota International Health Volunteers, United States of America; lehrlich@mihv.org

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P1: Poster Session 1: Expanding Contraceptive Access to Populations with Need

**Time:** Monday, 16 November 2009: 11:00am - 11:30am  
**Location:** Pre-Conference Area

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**P1: 1**
The Impact of Unmet Need and Discontinuation on the Total Fertility Rate: An Assessment to Inform Public Policy in Jordan
Douglas Heisler
Futures Group International, Jordan/Health Policy Initiative, Task Order 1; dheisler_mailbox@yahoo.com
P1: 2

What are the Changes in the Contraceptive Pattern and Behavior in the Process of Fertility Transition of China? 1988-2001
Xiaoying Zheng, Qiang Ren, Lei Zhang, Zhijian Cui, Quyuan Chen, He Chen
Institute of Population Research/WHO Collaborating Center of Reproductive Health and Population Science, China, Peoples Republic of; xzheng@pku.edu.cn
P1: 3

Human Security and Sexuality in the IPPF Africa Region
Patrick Orottin, Cheick Ouedraogo, Tewodros Melesse
International Planned Parenthood Federation Africa Region, Kenya; porotin@ippfaro.org
P1: 4

Reproductive Health Supplies in Emergency Settings
Maaike van Min, Louise Lee Jones
Mariestopes International (Msi), Belgium; maaike.vanmin@mariestopes-org.be
P1: 5

KAP about Family Planning (FP) among currently married Afghan refugee women in reproductive ages, residing in Karachi Pakistan.
Hina Abdul Hamid Ladha, Mehtab Karim, Sarah Saleem
The Aga Khan University, Community Health Sciences Department, Karachi, Pakistan; hina.ladha@aku.edu
P1: 6

Outreach Model Assessment
James, Onziga Geria, Fred, Kintu Mubiru, Dr. Justine Coulson
Mariestopes Uganda, Uganda; geria2006@yahoo.co.uk
P1: 7

Integration of family planning with health facility and community-based services: Multi-country data on the extent of Lactational Amenorrhea Method (LAM) counseling and the transition from LAM to other modern contraceptive methods
Justine Avinash Kavle, Irit Sinai, Sujata Bijou, Victoria Jennings
Georgetown University, Institute of Reproductive Health and School of Medicine, Department of OB/GYN; jak88@georgetown.edu
P1: 8

Knowledge of Some Ghanian Service Providers on the Reproductive Rights and Reproductive Options Available to HIV-Positive Ghanian Women
Amos Kankponang Laar
School of Public Health, University of Ghana, Legon, Ghana; aklaar@yahoo.com
P1: 9

Increasing Number of People having Access to Counseling and Non-Prescriptive Methods of Family Planning Commodities in 16 COMPASS LGAs of Kano State, Nigeria.
Abdul Hamid Abdullahi Bagara
Community Health and Research Intitative, Nigeria; aabagara@gmail.com
P1: 10

Identifying different stages in community mobilization for Family Planning use
Feven Tassew, Seifu Tadesse, Frehywot Esthetu, Barbara Pose
CARE International, SRH Programme, Ethiopia; FevenT@care.org.et
P1: 11

Contraceptive use and its determinants in Central India: A comparative study of tribal and non-tribal population
Ravendra Kumar Sharma1, Manju Rani2
1Regional Medical Research Centre for Tribals (ICMR), India; 2Government Degree College, Chhapaurli, Baghpat (Uttar Pradesh), India; ravendra_s@yahoo.com
P1: 12

Unmet Need for Contraception in India: Trends and Differentials
Ulilimri Venkata Somayajulu
Sigma Research and Consulting, India; somayajulu.uv@sigma-india.in
P1: 13

Market Segmentation to Reduce Inequity in Access and Use of Family Planning in Latin America and the Caribbean
Dana Aronovich, Nora Quesada, Disha Ali, Carolina Arauz, Juan Agudelo, Sonia Anderson
USAID | DELIVER PROJECT, United States of America; daronovich@jsi.com
P1: 14

Unmet need for family planning in India: factors affecting and actions required
Manas Ranjan Pradhan1, Hiralal Nayak2
1MAMTA Health Institute for Mother and Child, New Delhi, India; 2International Centre for Research on Women, New Delhi, India; manasranjanpradhan@rediffmail.com
P1: 15

Comparing Factors Behind the Unmet Need for Limiting and Spacing Births in Sub-Saharan Africa
Keriann Schulkers, Issakha Diallo, Diana Silimperi, Jennifer Lizow
Management Sciences for Health, United States of America; idiallo@msh.org
P1: 16

Increasing Access to Family Planning Services Among Indigenous Groups
Elizabeth Mallas1, Lucia Merino2, Marisela De La Cruz1, Alejandro Silva2, Gustavo Gütiérrez2, Vilma Morales de Oquendo3, Carlos Bauer4, Edwin Morales4, Sara Netzer5

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22
A02: Reaching Youth: Programs for Adolescents

**Time:** Monday, 16 November 2009: 11:30am - 1:00pm  
**Location:** Sheena Hall

**Session Chair:** Robert William Blum  
**Session Chair:** Abeja Apunyo

**A02: 1**

A Holistic Approach to Reproductive Health Interventions: Talk 2 Me Case Study  
*Ogehenefego Onome Isikwenu*¹, *Rachel Jacobson*², *James Omokiti*³, *Dosunnu Nurudeen*⁴

¹Inspiro Communications & Media, Nigeria; ²Global Youth Coalition on HIV/AIDS; ³Youth Network on Population & Development; ⁴PET NYSC, Delta State;  
figobud@yahoo.com

**A02: 2**

Catalyzing Change: Lessons from DISHA: A program to promote Healthy Young people in India  
*Sushmita Mukherjee*

International Center for Research on Women, India; smukherjee@icrw.org

**A02: 3**

Using private sector funded mass media campaign and NGO alliances to reach FP/RH underserved women and youth in Guatemala  
*Maria Teresa Ligoria*

RTI International, Guatemala; tligorria@rti.org

**A02: 4**

Giving young women in Kenya an opportunity to use contraceptive implants instead of short-acting methods: preliminary results on acceptability  
*David Hubacher*¹, *Alice Olawo*², *Caroline Kemunto*³, *James Kiarie*⁴

¹Family Health International, United States of America; ²Family Health International, Kenya; ³University of Nairobi Institute of Tropical and Infectious Diseases;  
dhubacher@fhi.org

**A02: 5**

Knowledge, Perception and Attitudes of Refugee youths in Oru refugee camp, Nigeria towards contraceptive use  
*Kehinde Olaoluwa Okanlawon*

Obafemi Awolowo University, Ile Ife, Nigeria; okanlawon_kehinde@yahoo.com

B02: Contraceptive Use: Levels and Trends

**Time:** Monday, 16 November 2009: 11:30am - 1:00pm  
**Location:** Meera Hall

**Session Chair:** John May  
**Session Chair:** Dorothy Byanssi Balaba
B02: 1
Contraceptive Use among at-risk women in the Kumasi metropolis of Ghana.
Baafuor Opoku

B02: 2

C02: Psycho-social Aspects of FP
Time: Monday, 16 November 2009: 11:30am - 1:00pm
Location: New Hall #1
Session Chair: Anju Malhotra
Session Chair: Elly Mugumya

C02: 1

Factors influencing family planning choices among women in the Hohoe district of Ghana.
Easmon Otupiri1, Charity Vivian Mote2, Harry Tagbor1, Ernestina Oforiwa Alowuah2

C02: 2

Social Determinants for Sustained Use of Family Planning (FP)
Feven Tassew, Berissa Abdela, Yalemshe Mekonnen, Yosef Alemu, Anna Summer, Barbara Pose
CARE International in Ethiopia, SRH Program Unit, Ethiopia; fevenT@care.org.et

C02: 3

Offering Socially and Culturally Acceptable FP Methods: Who Accepts and What Were They Doing Before?
Caroline Mackenzie1, Katherine Tumlinson2, Mareden Solomon1, Rick Homar3, Kirsten Kruger2, Susan Igras3, Abdikadir Ore4, Abdullahi Mahat Daud4, Fatuma Iman5, David Adriance6

C02: 4

Variations in Unmet Need for Contraception over the Lifecourse
Susan M. Lee-Rife, Anju Malhotra
International Center for Research on Women, United States of America; sleerife@icrw.org

C02: 5

Effects of economic status and family planning ideology on married women’s fertility intentions in Ghana and Kenya
Agbessi Amouzou, Stan Becker
Johns Hopkins Bloomberg School of Public Health, United States of America; aamouzou@jhsph.edu

D02: Integrating FP and HIV Programs II
Time: Monday, 16 November 2009: 11:30am - 1:00pm
Location: Victoria Ballroom
Session Chair: Bocar Diallo
Session Chair: Fredrick E Makumbi

D02: 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
Grace Nagendi1, Charles Nqobi2, Betty Farrell1, Isaac Achwal1, Nalin John1, Henry Kakande1, Hannah Searing2, Laura Subramanian3

D02: 2
Demand for Family Planning among women VCT clients: The need for Integration, Dessie town, Northeast Ethiopia
Dessalew Emway Altaye¹, Mesfin Addisse¹, Yilma Melkamu²
¹Engender Health, Ethiopia; ²Addis Ababa University School of Public Health; dessalew98@yahoo.com

D02: 3
Service delivery characteristics associated with contraceptive use among youth clients in voluntary counseling and HIV testing clinics with integrated family planning services
Joy Noel Baumgartner¹, Rose Otieno-Masaba³, Mark Weaver¹, Thomas W. Grey¹, Heidi Reynolds¹
¹Family Health International, United States of America; ²Family Health International, Kenya; ³MEASURE Evaluation, United States of America; jbaumgartner@fhi.org

D02: 4
The Need for Reproductive Health Services Among HIV-Positive Women in Zimbabwe
Lorrie Gavin, Galavotti Christine
US Centers for Disease Control, United States of America; lcg6@cdc.gov

D02: 5
Increasing support for family planning as HIV prevention: identification of influential individuals and stakeholder perceptions
Tricia Petruney¹, Sarah V Harlan¹, Lipika Nanda¹, Mukesh Janbandhu², Elizabeth T Robinson¹
¹Family Health International, United States of America; ²Family Health International, India; tpetruney@fhi.org

E02: Contraceptive Technology II

Time: Monday, 16 November 2009: 11:30am - 1:00pm
Location: New Hall #2

Session Chair: Paul Blumenthal
Session Chair: Bitra George

E02: 1
Fertility Awareness-based Methods and Gender
Iri Sinaï, Sujata Bijou
Georgetown University, Institute for Reproductive Health, United States of America; sinaii@georgetown.edu

E02: 2
Increasing Access by Introducing a Low-Cost Contraceptive Implant in Resource Constrained Countries
Markus I Steiner³, Diane Luo¹, Aida M Cancel¹, David Jenkins¹, David Asante¹, Heather Vahdat¹, Haizhen Meng¹
¹Family Health International, United States of America; ³Independent Consultant; msteiner@fhi.org

E02: 3
Three Female Condoms: Which One Do South African Women Prefer?
Carol Joannis¹, Mags Bekinska¹, Jenni Smit¹, Catherine Hart¹, Katie Tweedy¹
¹Family Health International, United States of America; ²Reproductive Health and HIV Research Unit, Witwatersrand University, South Africa; cjoannis@fhi.org

E02: 4
Pattern of Vaginitis Among Intra-uterine Contraceptive Device Users In Ibadan, South- Western Nigeria
Stella-Maris Ngozi Okonkwo, Michael Abiola Okunlola, Adebowale Abimbola Olutayo, Akinlade Olawumi Adeleke, Oladosu Akanbi Ojengbede
University College Hospital, Ibadan, Nigeria; ellesfashions@yahoo.com

E02: 5
Expanding Contraceptive Options Through Incremental Improvement in Existing Technology and Developing Totally New Methods
Jeff Spieler
USAID, United States of America; jsipieler@usaid.gov

F02: Promoting FP through Digital, Mobile and Wireless Technologies

Time: Monday, 16 November 2009: 11:30am - 1:00pm
Location: Albert Hall

Session Chair: Julie Wiltshire

F02: 1
Mobile and Wireless Technologies in Support of Family Planning Programs: Present and Future Solutions for Faster Reporting without Sacrificing Data Quality
David Charles Cantor¹, Virginia Lamprecht²
¹ICF Macro, United States of America; ²USAID/GH/PRH/SDI; David.C.Cantor@macrointernational.com

F02: 2
Family planning via mobile phones: Proof-of-concept testing
Katherine Sarah Lavoie¹, Victoria H Jennings¹, Meredith Puleio¹, Priya Jha¹, Rebecka I Lundgren¹
¹Georgetown University, United States of America; ²Institute for Reproductive Health, India; ks124@georgetown.edu

F02: 3
Toll-free hotline spreads information on family planning services throughout the DRC
Jamaica Corker
Population Services International, United States of America; jcorker@psicongo.org

F02: 4
A03: Reaching Youth: Contraceptive Access and Use

**Time:** Monday, 16 November 2009: 2:00pm - 3:30pm  
**Location:** Sheena Hall

**Session Chair:** Eliya Zulu  
**Session Chair:** Laurie Zabin

**A03: 1**  
**Predictors of contraceptive use among young women in urban northern Nigeria**

Mu'awiyyah Sufiyah, Stella Babalola, Hadiza Babayaro  
Johns Hopkins University Center for Communication Programs Ku Saurara Project, Nigeria; sufyanmb@yahoo.com

**A03: 2**  
**Changing Dynamics of Contraceptive Use among Young Adults in India**

Usha Ram  
International Institute for Population Sciences, India; usharam@iips.net

**A03: 3**  
**Peer Educators and School Support: we need education and teachers to support our work on ASRH arena**

Regina Benevides¹, Ana Jacinto¹, Arlindo Folige¹, Ásne Aarhus Botillen¹, Kari Cruz¹, Carolyn Boyce²  
¹Pathfinder International, Mozambique; ²Ministry of Education and Culture, Mozambique; ³Independent Consultant; jpacca@pathfind.org

**A03: 4**  
**Improving Contraceptive Access and Use Among the Youth in Lungwena and Makanjira Areas in Rural Malawi**

Andrew Ngwira, Effie Chipeta, Linda Kalliani-Phiri, Frank Taulo  
University of Malawi, College of Medicine - Centre for Reproductive Health; effie_chipeta@yahoo.com

**A03: 5**  
**Assessment of the Straight Talk Foundation (STF) Peer Education Approach to sex education in Arua and Bugiri Districts in Uganda.**

Julie Wiltshire, Catharine Watson, Jeralom Omach, Patrick Walugembe  
Straight Talk Foundation, Uganda; jwiltshire@straighthalkeuganda.org

B03: Contraceptive Use: Levels and Trends II

**Time:** Monday, 16 November 2009: 2:00pm - 3:30pm  
**Location:** Meera Hall

**Session Chair:** Betty Kyaddondo  
**Session Chair:** Anne R. Cross

**B03: 1**  
**Strong Predictors of the Unmet Need for Limiting and Spacing Births in Sub-Saharan Africa**

Keriann Schukers, Issakha Diallo, Jennifer Litzow, Diana Silimperi  
Management Sciences for Health, United States of America; idiallo@msh.org

**B03: 2**  
**How Can You Address the Sexual & Reproductive Health Needs of Clients - Including Unmet Family Planning Needs - if You Cannot Say the Word “Sex”**

Caroline Mackenzie¹, Marsden Solomon¹, Alice Olawo¹, Ruth Mula¹, Diane Kamar¹, Dorcas Kameta¹, John Odondi¹, Margaret Meme¹, Peter Mwarogo¹  
¹Family Health International, Kenya; ²Division of Reproductive Health, Ministry of Public Health and Sanitation, Kenya; ³National AIDS and STDs Control Program, Ministry of Medical Services, Kenya; ⁴Formerly Provincial Medical Officer’s Office, Rift Valley, Kenya; cmackenzie@fhi.org

**B03: 3**  
**Wanted and Unwanted Fertility, Need for Family Planning and Contraceptive Use Dynamics in India**

Hemkothang Thungdim¹, Nikhilsh S. Parchure²  
¹International Institute for Population Sciences, India; ²Population Research Centre, Sagar, India; lhungdim_hem@yahoo.com

**B03: 4**  
**Retrospective case notes review of Minilaparotomy and No-Scalpel Vasectomy procedures performed at Dessie FGAE clinic, North East Ethiopia: a 10-year period review**

Netsanet Fetene  
Engender Health, Ethiopia; netsanetfetene@yahoo.com
C03: Gender as a Social Determinant in FP

Time: Monday, 16 November 2009: 2:00pm - 3:30pm
Session Chair: Mubarak Mabuya
Session Chair: (Nora) Lynn Bakamjian

C03: 1
Do contraceptives fail? Investigating Claims of Contraceptive Failure among Women of Reproductive Age in Nigeria
Oladipupo Banji Ipadoeola, Samson B Adebayo, Jennifer O Anyanti
Society for Family Health, Nigeria; ladiipadeola@yahoo.com

C03: 2
Trends in women’s autonomy, sexual activity and contraceptive use in sub-Saharan Africa: A multi-country analysis
Carle J. Munstering, Michelle J. Hindin
Johns Hopkins Bloomberg School of Public Health, United States of America; cmunthe@jhsphs.edu

C03: 3
Gender equitable teachers support contraception and small family norms: Findings from a school based intervention in India
Pranita Achut, Nandita Bhatia, Ravi Verma
International Center for Reserach on Women, India; rverma@icrw.org

C03: 4
Gender Equity, Gendered Roles and Reproductive Health in Maasai Women in Northern Tanzania
Lauren Katherine Birks1, Yadra Roggeveen2, Jennifer Margaret Hatfield3
1University of Calgary, Canada; 2Endulen Hospital, Tanzania; likbirks@ucalgary.ca

C03: 5
Qualitative Research on Gender Norms and Family Planning Decision-Making in Tanzania
Sidney Schuler, Elisabeth Rottach, Peninah Mukiri2
1AED, United States of America; 2Steadman group; sschuler@aed.org

D03: Integrating FP and Maternal and Child Health I

Time: Monday, 16 November 2009: 2:00pm - 3:30pm
Location: Victoria Ballroom
Session Chair: Hanifah Sengendo Naamala
Session Chair: Mario Festin

D03: 1
FP Use Among Postpartum Women in 15 Countries
Maria Raquel Borda, Bill Winfrey, Catherine McKaig, Angela Nash-Mercado
1Futures Group, United States of America; 2Futures Institute, United States of America; 3Jhpiego—an affiliate of Johns Hopkins University, United States of America; mborda@futuresgroup.com

D03: 2
A literature review of the integration of family planning services with other health services
Anne Katharine Sebert Kuhlmann, Christine Galavotti, Lorrie Gavin
1MANILA Consulting Group, Inc., United States of America; 2U.S. Centers for Disease Control and Prevention; zmt8@cdc.gov

D03: 3
- The fight for maternal and child health is won in the community —
Fevver Tassew, Frehywot Eshetu, Sara Buchanan, Barbara Pose
CARE International, Sexual reproductive Health Program Unit, Ethiopia, Ethiopia; FevenT@care.org.et

D03: 4
Integrating Family Planning into Postpartum Care: A Postpartum Family Planning Needs Assessment in Cap Haitien, Haiti
Eva Lathrop1, Youseline Telemaque1, Peggy Goedken1, Carrie Cwiak1
1Emory University, United States of America; 2Konbit Sante NGO, USA/Haiti; evalathrop@hotmail.com

D03: 5
A model of integration: Postpartum family planning through a community based maternal and newborn program
1Johns Hopkins Bloomberg School of Public Health, Bangladesh; 2Johns Hopkins Bloomberg School of Public Health, Baltimore, MD; 3ACCESS-FP of Jhpiego; 4RTM International, Bangladesh; sahmed773@yahoo.com

E03: FP as a component of SRH

Time: Monday, 16 November 2009: 2:00pm - 3:30pm
Location: New Hall #2
Sponsor: UNFPA

E03: 1
Prioritizing FP/SRH and working in the new aid environment
Makane Kane
UNFPA, Mali; ortayli@unfpa.org

Family Planning as part of comprehensive SRH
Berhanu Legesse, Helene Amedemikael
UNFPA; ortayli@unfpa.org

Financing FP/SRH programmes, and prioritizing them within National Plans and Budgets
Dia Timmermans
Independent Consultant; ortayli@unfpa.org

F03: Effective Programming and Service Delivery II

Time: Monday, 16 November 2009: 2:00pm - 3:30pm
Location: Albert Hall

Session Chair: Florence Maureen Mirembe
Session Chair: Frank Taulo

F03: 1
An Innovative Approach to Increasing Uptake of Long-Term Family Planning Methods in Zambia
Josselyn Neukom1, Jully Chilambwe2

1Population Services International; 2Society for Family Health, Zambia; josselynneukom@msn.com

F03: 2
Contraceptive initiation simplified: Health providers experience using family planning checklists
Beatrice Atieno Ochien1, Violet Bukusi1, Solomon Marsden1, Rick Homan1, Trinity Zan2, Eva Canoutas2

1Family Health International, Kenya; 2Family Health International, North Carolina, USA; bochieng@fhi.org

F03: 3
Current Practices of IUD Insertion Among Physicians in Central America
Isolda Fortin1, Benjamin Nieto-Andrade1, Pedro Jaime3

1Population Services International, Guatemala; 2Population Services International; 3Population Services International; bandrade@pasmocare.org

F03: 4
How well do national family planning guidelines from Africa adhere to international guidance?
Lucy C Wilson1, Erin McGinn1, Irina Yacobson1, John Stanback1

1Family Health International, United States of America; 2EngenderHealth, United States of America; lwilson@fhi.org

F03: 5
Removing barriers to DMPA continuation: Field-testing a provider job aid in Senegal
Kate Rademacher1, Boniface Sebikali2, Lucy Harber3, Babacar Gueye2, Fatou Ndlaye2, Carol Cisse2, Joy Noel Baumgartner2

1Family Health International, United States of America; 2IntraHealth; krademacher@fhi.org

P2: Poster Session 2: FP Trends and Determinants and Linkages with HIV

Time: Monday, 16 November 2009: 3:30pm - 4:00pm
Location: Pre-Conference Area

P2: 1
Sex-Refusal Skills and Safer-Sex Practices of Women in Osun State of Nigeria
Bayode Isaiah Popoola
Otabiemi Awolowo University, Ife Ife, Nigeria, Nigeria; bayodep@yahoo.com

P2: 2
Understanding HIV-positive Women’s Barriers to FP/RH Services: PLHIV and Provider Knowledge and Experiences in Kenya
Beatrice Okundi
Health Policy Initiative, Kenya; bokundi@futuresgroup.com

P2: 3
Contextual factors related to contraceptive use among women in Offinso district, Ghana
Easmon Otupiri1, Juliana Bosomprah1, Roderick Larsen-Reindorf1, Agatha Bonney1

1Kwame Nkrumah University of Science and Technology-School of Medical Sciences, Ghana; 2Komfo Anokye Teaching Hospital; 3Ghana Health Service; easmono@yahoo.com

P2: 4
Condom and HIV Prevention among Indian Youth
Ulilmir Venkat Somayajulu, Tilak Mukherji
Sigma Research and Consulting, India; somayajulu.uv@sige-india.in

P2: 5
Determinants of Contraceptive Use among HIV infected Women attending Care in an Urban Center
Fred Ssewankambo, Carol Nabwera, Gertrude Namale, Ibrahim Lutalo, Andrew Kambugu
Infectious Diseases Institute, Uganda; ssewaf@yahoo.com
P2: 6
Using Integrated RH/HIV Mobile Service Units as a Source of Modern Family Planning Methods in Underserved Areas: The Example of FHI-SA and the DoH MSU project in South Africa
Francis Ogojo Okello, Innocent Ngezni, Hector Rakheti, Tembeka Sonkwele
Family Health International, United States of America; fokello@fhi.org
P2: 7
Meeting the FP needs of people living with HIV through integration and community based approaches: The Tanzania experience
Rita Badiani, Damian Daniel, Judith Rwakiyendela, Diana Shuma, Joseph Banzi, Olivia Sumpter
Pathfinder International, Tanzania; RBadiani@pathfind.org
P2: 8
An Expedition from Clinics to Community: Understanding Family Planning Program in India
Manas Ranjan Pradhan¹, Hiralal Nayak²
¹MAMTA Health Institute for Mother and Child, New Delhi, India; ²International Centre for Research on Women, New Delhi, India; manasranjanpradhan@rediffmail.com
P2: 9
Resilience to Climate Change in Ethiopia: Do Fertility and Reproductive Health Matter?
Akilu Kidanu¹, Kimberly Rovin², Karen Hardee³
¹Miz-Hasab; ²Population Action International, United States of America; KHardee@popact.org
P2: 10
Covariates of Contraceptive Use: A Cross-Cultural Study of Three Large Indian States
Ravi K. Verma, Ajay K. Singh, Susan M. Lee-Rife
International Center for Research on Women, United States of America; slerife@icrw.org
P2: 11
Does use of contraceptive effect overweight/obesity among Indian women?
Prawei Kumar Agrawal¹, Sutapa Agrawal²
¹India HIV/AIDS Alliance, India; ²South Asian Centre for Chronic Disease Research; praween_agrawal@yahoo.com
P2: 12
Multi varied cross sectional analysis of some key determinants of total fertility rate in sub Saharan Africa: Evidence for effective FP programming in Nigeria
Omoride Ezire, Jennifer Anyanti, Samson Adebayo, Banji Oladipo
Society for Family Health, Nigeria; oezi@sfhng.org
P2: 13
Integration of family planning (FP) into PMTCT services in Kenya
Jennifer Katunge Liku, R. Masaba, M. Solomon, M. Kuyoh, E. Jackson
Family Health International, Kenya; jliku@fhi.org
P2: 14
Éléments de relance de la planification familiale au Togo dans un processus d’évolution lente de la prévalence
Koffi Koumataguenou
Population Services Internationales/Togo (PSI/Togo), Togo; koffifils@yahoo.fr
P2: 15
Does availability of HIV-related health services affect fertility preferences and contraceptive use in four Sub-Saharan African countries?
Akinrinola Bankole¹, Ann E. Biddlecom², Isaac F. Adewole³
¹Guttmacher Institute, United States of America; ²University of Ibadan, Nigeria; ³abankole@guttmacher.org
P2: 16
Assessing Contraceptive Knowledge Attitude and Practice among Women of Reproductive Age in Kabusa Community Abuja
Chukwudera Bridge Okeke, Michael Olasimbo Kofoworola
Center for Right to Health, Nigeria; talkwitody@yahoo.com
P2: 17
The Power of Misinformation on Contraceptive Decision Making: Ghanaian Example
Sirina Reddy Keesara, Martha Campbell
Venture Strategies for Health and Development, United States of America; sirina.keesara@gmail.com
P2: 18
HIV/RH integration in hard to reach populations, case of female Commercial Sex workers in Uganda
Sarah Mbabazi, Muna Shalita
Program for Accessible Health, Communication and Education, Uganda; pace@pace.org.ug
P2: 19
Assessing the Reproductive Health Training Needs of Religious Leaders: A Pilot Study
Omaima El-Gibaly
Assiut University, Egypt; oelgibaly@yahoo.com
P2: 20
The effect of women empowerment on modern contraceptive use in Uganda
Simon Sebina Kibirig, B. Kwagala, E. Sekataka
Makerere University School of Public Health, Uganda; pskibira@musph.mak.ac.ug
P2: 21
Integrated Services: How do we measure and evaluate?
Saumya RamaRao¹, Estela Rivero-Fuentes², Charlotte Warren³, Saiqa Mullick³, Harriet Birungi³, Ian Askew³, John Townsend²
¹Population Council, United States of America; ²El Colegio de Mexico, Mexico; ³sramaco@popcouncil.org
A04: Reaching Youth: Programs for Adolescents II

**Time:** Monday, 16 November 2009: 4:00pm - 5:30pm  
**Location:** Sheena Hall

**Session Chair:** Adesegun Fatusi  
**Session Chair:** Patricia Wamala Nansamba

**A04: 1**
Religiosity, Sexual Debut and Contraceptive Use among In-School Adolescents in Lagos State, Nigeria  
*Olayinka Yetunde Asubiaro, Adesegun O Fatusi, Uche Onwudiegwu*  
Obafemi Awolowo University, Ile-Ife, Nigeria; yinkaasubiaro@yahoo.com

**A04: 2**
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  
*Susan Igras, Rebecka Lundgren, Sujata Bijou, Marie Mukubatsinda, Elizabeth Salazar*  
Institute for Reproductive Health/Georgetown Univ, United States of America; smi6@georgetown.edu

**A04: 3**
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.  
*Esther Babirye Kagwa, Michelle Hindin*  
Johns Hopkins University, United States of America; ekaggwa@jhsph.edu

**A04: 4**
Evaluation of Community- Based Youth Reproductive Health Communication Intervention in Bihar for Evidence Based Advocacy and Scale Up  
*Elkan Elijah Daniel, Rekha Masilamani, W. Sita Shankar*  
Pathfinder International, India; eedaniel@pathfind.org

**A04: 5**
Adolescents living with HIV require sexual and reproductive health information and services  
*Harriet Birungi*, Francis Onyango, Juliana Nyombi, Hannington Nyinkavu  
1Population Council, Kenya; 2TASO, Uganda; hbirungi@popcouncil.org

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B04: Assessing the Costs and Benefits of Providing Sexual and Reproductive Health Care

**Time:** Monday, 16 November 2009: 4:00pm - 5:30pm  
**Location:** Meera Hall

**Session Chair:** Elizabeth Laura Lule

**B04: 1**
Adding It Up: The costs and benefits of interventions in sexual and reproductive health in Ethiopia  
*Aparna Sundaram*, Michael Vlassoff, Lisa Remez, Akinrinola Bankole  
1Unknown; “Guttmacher Institute, USA; sshaw@ippf.org

**B04: 2**
The human and Economic impact of RH supplies and shortage and stock outs in Bangladesh  
*Abul Barkat*  
IPPF, United Kingdom; sshaw@ippf.org

**B04: 3**
Adding it up: the costs and benefits of interventions in sexual and reproductive health in Uganda  
*Michael Vlassoff, Aparna Sundaram, Frederick Mugisha, Lisa Remez, Akinrinola Bankole*  
1Unknown; “Economic Policy Research Center,” “Guttmacher Institute, USA; sshaw@ippf.org

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C04: Psycho-social Aspects of FP II

**Time:** Monday, 16 November 2009: 4:00pm - 5:30pm  
**Location:** New Hall #1

**Session Chair:** Janine Barden-O’Fallon  
**Session Chair:** Marsden Solomon

**C04: 1**
Contraceptive practice prior to female sterilization in Ghana: 1996-2005  
*Hilary Megan Schwandt*, Andrea Creanga, Kwabena Antwi Danso, Frank Ankobea-Kokrooe, Cornelius Archer Turpin, Michelle Hindin  
1Johns Hopkins Bloomberg School of Public Health, United States of America; 2Kwame Nkrumah University of Science and Technology School of Medical Sciences, Kumasi, Ghana; hschwandt@jhsph.edu
C04: 2
"Pages Of Life" - Research on the Impact of Social Merchandising
Marcio Ruiz Schiavo1, Scott Connolly2
1Comunicarte, Brazil; 2Population Media Center, US; mschiavo@comunicarte.com.br

C04: 3
Finding the right messages about the IUD
Claire Stokes, James Kajuna, Risha Hess
PSI Tanzania, Tanzania; cstokes@psi.or.tz

C04: 4
Influence of Independent and Proximate Variables in Predicting Ever-use, Current-use and use of condom during last sex in Nigeria.
Akanni Ibuken Akinyemi1, Funmilayo Banjo, Opeyemi Abiola Fadeyibi, Olusina Bamiwuye, Alfred Adeagbo Adewuyi
Obafemi Awolowo University, Nigeria; akakanni@yahoo.ca

D04: Integrating FP and HIV Programs III

Time: Monday, 16 November 2009: 4:00pm - 5:30pm
Location: Victoria Ballroom

Session Chair: Manjula Lusi-Narasinghan
Session Chair: Grace Nagendi

D04: 1
Contraception continuation and initiation by newly diagnosed HIV-infected women in Malawi
Gretchen Sauer Stuart1, Rosalie Dominik1, Francis E. A. Martinson1, Kimberly A. Powers1, David A. Chilongoli1, Emmie D. Msiska1, Emma I. Kachipapa2, Chimwemwe D. Mphande3, Rob Stephenson4, Amy O. Tsui5, Mina C. Hosseinpour6,7, Irving Hoffman8
1University of North Carolina Chapel Hill, United States of America; 2University of North Carolina Project, Lilongwe, Malawi; 3Emory University, Atlanta, Georgia, USA; 4Johns Hopkins University, Baltimore, MD, USA; 5gstuart@med.unc.edu

D04: 2
Improving integration of family planning into ART services: Experiences from development of a provider orientation module
Jane Alai1, Solomon Marsden1, Tom Marwa1, Sharon Tsui1, Violet Ambundo2, Dickson Mwakangalu2, Mary Gathitu2, Margaret Gitau2
1Family Health International, Kenya; 2JHPIEGO; 3Family Health International, USA; 4USAID-AIDS Population Health Integrated Assistance (USAID APHA II) – Rift Valley; 5USAID APHIA II Coast; 6Division of Reproductive Health (DRH) – Ministry of Public Health and Sanitation; 7National AIDS and STIs Coordinating Programme (NASCOP) – Ministry of Medical Services/Ministry of Public Health and Sanitation; 8jalaai@fhi.org

D04: 3
Integrating HIV and Family Planning Services: Are Providers Ready?
Susan Patricia Enea Adamchak1, Barbara Janowitz1, Jennifer Liku1, Emmanuel Munyambanza1, Thomas Grey1, Rick Hom2, Emily Keys1
1Family Health International, United States of America; 2Family Health International, Nairobi, Kenya; 3Family Health International, Kigali, Rwanda; sadamchak@fhi.org

D04: 4
Providing family planning in Ethiopian voluntary HIV counseling and testing facilities: Client, counselor and facility-level considerations.
Heather Bradley1, Duff Gillespie2, Aklilu Kidanu1, Yong-Ting Bonnenfant2, Sabrina Karklins2
1Johns Hopkins Bloomberg School of Public Health, United States of America; 2Miz-Hasab Research Center, Ethiopia; hbradley@jhsphs.edu

D04: 5
The Effect of VCT Acceptance and Uptake of Antiretroviral Treatment on Modern Contraceptive Use Among Women in Rakai, Uganda
Fredrick E Makumbi1, Gertrude F Nakigozi2, Tom Lutalo1, Joseph Kagayi1, Joseph Sekasanvu2, Absalom Settuba2, David Serwada1, Maria Wawer1, Ron Gray2
1Makerere University School of Public Health, Uganda; fmakumbi@yahoo.com

E04: Hormonal Contraception and HIV

Time: Monday, 16 November 2009: 4:00pm - 5:30pm
Location: New Hall #2
Sponsor: Family Health International

E04: 1
Hormonal Contraception and HIV-1 Infectivity: an Overview
Ludo Lavreys, Jared Baeten
University of Washington; cmorrison@fhi.org

E04: 2
An Overview of hormonal contraception and HIV disease progression
Elizabeth M Stringer
University of Alabama at Birmingham; cmorrison@fhi.org

E04: 3
Hormonal Contraception and HIV Acquisition
Charlie Morrison
F04: Effectiveness of Community-based Distribution

Time: Monday, 16 November 2009: 4:00pm - 5:30pm
Location: Albert Hall

Session Chair: Nancy Pendarvis Harris
Session Chair: Wilfred David Ochan

F04: 1
Improving family planning utilization by repositioning family planning/reproductive health program through strengthening community based Health Service Extension Program (HSEP) in Ethiopia.
Dereje Ayele¹, Biniyam Ayele¹, Yemisirach Belaineh²
¹Ethiopian Public Health Association, Ethiopia; ²Packard Foundation Country Advisor; derejeayele@yahoo.com

F04: 2
What works in family planning interventions: A systematic review of the evidence
Lisa M. Basalla¹, Ilene Speizer¹, Anna Schurmann¹, Fariyal Fikree², Gwen Morgan³
¹University of North Carolina, United States of America; ²Population Reference Bureau, United States of America; ³African Population & Health Research Center, Kenya; basalla@email.unc.edu

F04: 3
Scaling-up Community-based Distribution of Injectable Contraceptives in Uganda: Lessons Learned from Private and Public Sector Implementation
Angela Akol¹, Amanda Abbott², Kirsten Krueger², Patricia Wamala³
¹Family Health International Uganda, Uganda; ²Family Health International, North Carolina, USA; aakol@fhi.org

F04: 4
Findings from a Qualitative Study of a Pilot Community-Based Distribution of DMPA Program
Heather Lukolyo, Pamela Mukaire, Paige Anderson Bowen, Laura C. Ehrlich
Minnesota International Health Volunteers, United States of America; lehrlich@mihv.org
Tuesday, 17 November 2009

Plenary

**Time:** Tuesday, 17 November 2009: 8:30am - 9:30am  
**Location:** Victoria Hall

**Session Chair:** Chair: Dana Hovig, Marie Stopes International

**Criteria 20:** All Party Parliamentary Group on Population, Development and Reproductive Health and Parliamentary Hearings

Baroness Jenny Tonge, United Kingdom House of Parliament

**UNFPA Call for Action:** Reducing Inequities in Family Planning Access

Nurie Ortayli, United Nations Population Fund

**Foundation Strategies for Family Planning**

Musimbi Kanyoro, David and Lucile Packard Foundation

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

Tewodros Melese, International Planned Parenthood Federation/Africa Regional Office

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**A05: Neglected FP Issues**

**Time:** Tuesday, 17 November 2009: 9:30am - 11:00am  
**Location:** Sheena Hall

**Session Chair:** Maureen Kuyoh

**Session Chair:** Valerie DeFillipo

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**A05: 1**

The stalled fertility transition and family planning in Kenya

Ian David Askew⁵, Alex Ezeh⁵, John Bongaarts⁶, John Townsend⁷

¹Population Council, Kenya; ²African Population and Health Research Centre; ³Population Council, USA; ⁴iaskew@popcouncil.org

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**A05: 2**

Family Planning in sub-Saharan Africa: Progress or Stagnation?

John Cleland⁸, Robert Peter Ndugwa⁹, Eilya Zulu⁹

¹London School of Hygiene and Tropical Medicine, United Kingdom; ²African Population and Health Research Center, Nairobi Kenya; ³robert.ndugwa@lshtm.ac.uk

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**A05: 3**

Infertility: the hidden tragedy within family planning” OR “Tossing the family planning coin, infertility exposed: Perhaps an evenly-weighted coin will prove best practice?”

Sheryl Vanderpoel

World Health Organization, Switzerland; vanderpoels@who.int

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**A05: 4**

Population and Health in National Adaptation Programmes of Action (NAPAs) for Climate Change

Clive J. Mutunga, Karen Hardee

Population Action International, United States of America; cmutunga@popact.org

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**B05: Commodity Security II**

**Time:** Tuesday, 17 November 2009: 9:30am - 11:00am  
**Location:** Meera Hall

**Session Chair:** Moses Muwonge

**Session Chair:** Sarah C. Clark

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**B05: 1**

Contraceptive Security: Complete without Long-Acting and Permanent Methods of Contraception

Jane Wickstrom, Roy Jacobstein, L. Subramanian

EngenderHealth, United States of America; jwickstrom@engenderhealth.org

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**B05: 2**

The Procurement Planning and Monitoring Report: Towards Donor Coordination in Contraceptive Security

Trisha Long, Paul Dowling

USAID | DELIVER PROJECT, United States of America; tlong@jsi.com

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**B05: 3**

Health Sector Reforms and their Effects on Contraceptive Security: The Case of Malawi

Jayne Waweru¹, Samuel Chirwa¹, Suzy Sacher¹, Manondo Msafu²

¹USAID | DELIVER PROJECT, United States of America; ²Malawi Ministry of Health, Health Technical Support Services, Pharmacy Department; ssacher@jsi.com

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**B05: 4**

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The Strategic Pathway to Reproductive Health Commodity Security: Five years and 50 countries later – What have we learned?

Leslie Patykewich, Marie Tien
USAID | DELIVER PROJECT, United States of America; lpatykewich@jsi.com

B05: 5


Dana Aronovich, Disha Ali
USAID | DELIVER PROJECT, United States of America; daronovich@jsi.com

C05: Integrating FP and Maternal and Child Health II

Time: Tuesday, 17 November 2009: 9:30am - 11:00am

Session Chair: Liliane Christine Luwaga
Session Chair: Oladosu Ojengbede

Location: Albert Hall

C05: 1

Introduction of Post Placental/Partum IUD insertion (PPIUD) in Lusaka, Zambia: Feasibility of training nurse midwives

Sarah Prager1, Joss Neukom2, Pratima Gupta3, Jully Chilambwe4, Nomsa Siamwanza4, Maxine Eber1, B Vwalika5, Paul D Blumenthal1

1Population Service International; 2University of Washington; 3Society for Family Health; 4University of Zambia; 5Kaiser Oakland; jquarles@psi.org

C05: 2

Expanding Access to Contraceptives and Improving Couple Communication about Family Planning in West Africa – Nigeria: Lessons Learned

John Chukwudi Bako, Uzoamaka R. Okeke, Amaka J. Nnej

Society for Family Health, Nigeria; bakojohnchukwudi@yahoo.com

C05: 3

Quality of family planning service in Ethiopia

ABY SEIFU ESTIFANOS, Getnet Miltike Kassit

School of Public Health, Addis Ababa University, Ethiopia; seifu9@gmail.com

C05: 4

Assessing the need of a family planning component in the safe motherhood project in Western Uganda

Richard Semujju, Christine Namayanja

Mariestopes Uganda, Uganda; semurich@gmail.com

C05: 5

Piloting and Sustaining Post Partum IUD Services in Zambia

Josselyn Neukom1, Jully Chilambwe2, Nomsa Siamwanza2

1Population Services International; 2Society for Family Health, Zambia; josselynneukom@msn.com

E05: Men and Family Planning I

Time: Tuesday, 17 November 2009: 9:30am - 11:00am

Session Chair: Barbara Katende
Session Chair: Ali Hussien Zarzour

Location: Regal Hall

E05: 1

Is That a Vasectomy In Your Pocket?

Grace Lusiola, Fredrick Ndede, Nicholas Kanlisi, John M. Pile, Erin K. McGinn, A. Jensen, Isaiah Ndong

EngenderHealth, United States of America; emcginn@engenderhealth.org

E05: 2

Husband’s influence over use of modern family planning, in rural Ethiopia

Annabel Erulkar

Population Council, Ethiopia; aerulkar@popcouncil.org

E05: 3

Knowledge and current use of family planning service among males in the Ga East Municipality, Ghana

Peter Agyei-Baffour, Selina Ababio, Easmon Otupiri

Kwarne Nkrumah University of Science and Technology, Ghana; agyeibaffour@yahoo.co.uk

E05: 4

Male Involvement in Family Planning Decision Making in Ile-Ife, Osun State

Macellaина Yyninae Ijadunola1, Kayode Thadius Ijadunola2, Adepeju Esimai2, Titilayo Collette Abiona3, Olasegun Temitope Afolabi2

1Dept. of Community Health, O.A.U.T.H.C. Ile-Ife, Osun state, Nigeria; 2Dept. of Community Health, O.A.U, Ile-Ife, Osun state, Nigeria; 3Chicago state university, Illinois, U.S.A.; yijadun@yahoo.com

E05: 5

Psychosocial Support during Childbirth as a Catalyst for Modern Family Planning uptake in Nigeria: a Randomised Controlled Trial

Oladosu Ojengbede4, Imran O. Morhason-Bello4, Babatunde O. Adedokun5, Stan Becker4, Gbolahan Oni4, Amy Tsui2

1Department of Obstetrics and Gynaecology, University College Hospital/College of Medicine, Ibadan, Nigeria, Nigeria; 2Department of Epidemiology, Medical Statistics, and Environmental Health, College of Medicine, University of Ibadan; 3Gates Institute, Bloomberg School of Public Health, Johns Hopkins University; 4Centre for Population and Reproductive Health, College of Medicine, University of Ibadan; ladosu2002@yahoo.co.uk
F05: Contraceptive Practice in Asia

Time: Tuesday, 17 November 2009: 9:30am - 11:00am
Location: New Hall #1
Session Chair: Kuhu Maitra
Session Chair: Michelle J. Hindin

F05: 1
Contraceptive Use is More Equitable than Maternal-Child Care in India: Exploratory Analysis
Ram Faujdar
International Institute for Population Sciences, India; fram@iips.net

F05: 2
Contraceptive Use Pattern among Married Women in Indonesia
Ria Rahayu1, Iwu Utomo2, Peter McDonald3
1Indonesia National Family Planning Coordinating Board (BKKBN), Indonesia; 2Australian Demographic and Social Research Institute (ADSRI), The Australian National University (ANU); riayu_80@yahoo.co.id

F05: 3
Contraceptive Use and Method Choice in Urban Slum of Bangladesh
S. M. Mostafa Kamal
Islamic University, Kushtia-7003, Bangladesh; kamaliubd@yahoo.com

F05: 4
Evidence based decision making for increasing current use of oral contraceptive pills and condoms in the rural areas of Jharkhand, India.
Amajit Mukherjee1, Dan Rosen2
1Population Services International, Gurgaon, India; 2Population Services International, Washington DC, USA; amajit@psi.org.in

F05: 5
Innovations for Expanding Contraceptive Use in Rural Afghanistan
Douglas H. Huber1, Nika Seedi2, Khalil Samadi3, Hedayetullah Mushfiq4, Razia Rahimzai4
1IDEAS, Inc, United States of America; 2UNDP, Geneva, Switzerland; 3STEP for Health, Kabul Afghanistan; 4Management Sciences for Health, Kabul Afghanistan; 5BASICS, Kabul, Afghanistan; douglasshuber777@yahoo.com

G05: Costing and Tracking Funding for FP

Time: Tuesday, 17 November 2009: 9:30am - 11:00am
Location: New Hall #2
Sponsor: Population Action International

G05: 1
Re-Costing ICPD: Making the New Numbers Work for Advocacy
Suzanna Dennis, Clive Mutunga
Population Action International, United States of America; sdennis@popact.org

G05: 2
Donor Commodity Support Required to Scale-Up Family Planning Services in Low- and Middle-Income Countries
John Stover5, Eva Weissman5, John Ross5
5Futures Institute, United States of America; 5Futures Group International; sdennis@popact.org

G05: 3
Tracking European Donor ODA Funding for RH and RH Supplies: Challenges for Advocacy in a European context
An Huybrechts
International Planned Parenthood Federation - European Network; sdennis@popact.org

G05: 4
Euromapping – how the costings are used for advocacy!
Karen Hoehn6, Neil Datta6
6German Foundation for World Population (DSW), Belgium; 6European Parliamentary Forum on Population and Development (EPF); sdennis@popact.org

P3: Poster Session 3: Gender and Youth-Related Issues in FP

Time: Tuesday, 17 November 2009: 11:00am - 11:30am
Location: Pre-Conference Area

P3: 1
Men’s Reaction to wife’s covert use of contraceptives: Implication for Family Planning Practices in Southwest Nigeria
Peter Olasupo Ogunjuigbe1, Gbolahan Oni1, Sunday Adedini1
1Obafemi Awolowo University, Ile-Ife, Nigeria, Nigeria; 2Johns Hopkins Bloomberg School of Public Health, Maryland, USA; pogunjuyigbe@yahoo.com
P3: 2
Good practice in creating access to FP service for the rural youth: A case study on Dhalotake Egi Youth SRH Clinic
Feyera Assefa Abdisa
German Foundation for World Population (DSW) Ethiopia, Ethiopia; feyera.assefa@ethionet.et
P3: 3
Male Issues in Cases of Unwanted Pregnancy and Abortion Resolution in Southwest Nigeria
Peter Olasupo Ogunjuyibe, Ambrose Akintol, Ayotunde Titilayo, Akanni Akinseyi
Obafemi Awolowo University, Ille-Ife, Nigeria; pogunjuyibe@yahoo.com
P3: 4
Adolescent Reproductive Health Policy Implementation in Ghana: A Review of the Service Provision Component in the Accra Metropolis
Fred Gbagbo
Marie Stopes International Ghana, Ghana; gbagbofireyao2002@yahoo.co.uk
P3: 5
Utilization of Family Planning Services by Adolescents: A Katuba Experience.
Victor Silumwe, Kalenga Lusa
Katuba Community Association, Zambia; vsilumwe@yahoo.com
P3: 6
Factors Affecting Contraceptive Use and Method Choice Among Young Married Women in Bangladesh
S. M. Mostafa Kamal
Islamic University, Kushtia-7003, Bangladesh; kamaliubd@yahoo.com
P3: 7
Unmet Needs for Contraceptives for Young Undergraduates in Selected Tertiary Institutions in Southwestern Nigeria.
Ilhaye Abiola Odu, Lanre Olusegun Ikuteyip
Obafemi Awolowo University, Ille-Ife, Nigeria; t_odu@hotmail.com
P3: 8
The impact of voluntary activities of medical students in promotion of Family Planning.
Egide Abahuje
Family Planning Education Project, Rwanda; abegid1@gmail.com
P3: 9
SRH needs and service utilization of young students of Addis Ababa University
Yordanos Belayneh Molla
IC: Health Sector Development Prgram (HSDP), Ethiopia; jordi_belayneh@yahoo.com
P3: 10
Contraception Among Out of School Females
Kofoworola Abimbola Odeyemi1, AT Onajole1, BE Ogunowo2, B Segun2
1University of Lagos, Nigeria; 2Federal Ministry of Health, Abuja. Nigeria; kofoodeyemi@yahoo.com
P3: 11
Promoting Gender Equity as a Strategy to Change Contraceptive-Related Attitudes and Behavior among Young Men in Rural India
Ravi K. Verma1, Ajay K. Singh1, Vaishali Mahendra1, Susan M. Lee-Rife1
1International Center for Research on Women, United States of America; 1Independent Consultant; sleerife@icrw.org
P3: 12
Contraceptives Risk Perception and Sexual Negotiation in Marriage among Child bearing Rural Women in Southwest Nigeria
Ojo Melvin Agunbiade, Ayotunde Titilayo, Opatola Mustapha
Obafemi Awolowo University, Nigeria; ojomelvin@yahoo.com
P3: 13
Impact of Inter Spousal Communication on use of Modern Family Planning Methods in Nigeria
Samson Babatunde Adebayo, Chinazo Ujuju, Richard Fakolade, Jennifer Anyanti
Society for Family Health, Nigeria; sadebayo@sfhnigeria.org
P3: 14
A Study of Contraceptive Use Patterns Among Sexually Active Youths in Egbeda Local Government Area of Ibadan, Oyo State, Nigeria
Ranmilowo Titilope Jolajo, Kayode Amusan, Toyin Ayeni
Obafemi Awolowo University, Nigeria; ranmilowow@yahoo.com
P3: 15
Meeting the Family Planning Needs of Young Married Couples through the Private Health Sector: Evaluation of the Saathiya Youth Friendly Initiative in urban Uttar Pradesh
Aneesa Arur, Sara Sulzbach, Kathryn Banke
Adb Associates, United States of America; Aneesa_Arur@Abtassoc.com
P3: 16
Persistent high fertility in Uganda: Young people recount enabling factors and obstacles to use of contraceptives
Gorgette Nalwadda
Makerere University, College of Health Sciences, Uganda; gnalwadda@gmail.com
P3: 17
Access to Youth-Friendly Reproductive Health Services in Georgia
Tamar Khomasuridze, Lela Bakradze, Tea Jallashvili
United Nations Population Fund (UNFPA), Georgia; khomasuridze@unfpa.org
P3: 18
Mobilizing Married Youth in Nepal to Improve Reproductive Health
A06: Men and Family Planning II

Time: Tuesday, 17 November 2009: 11:30am - 1:00pm

Location: Sheena Hall

Sponsor: Family Health International

A06: 1
Factors that Influence Male Involvement in Sexual and Reproductive Health in western Kenya: a Qualitative Study

Monica Adhiambo Onyang'o¹, Sam Owoko¹, Monica Atieno Oguttu²
¹Boston University School of Public Health, United States of America; ²Kisumu Medical and Education Trust, Kenya

A06: 2
You started using family planning, what does he think? A study of men’s influence on contraceptive continuation in Nyando District, Kenya

Holly Burke, Constance Ambasa-Shisanya

Family Health International, United States of America; Dshattuck@fhi.org

A06: 3
Using Male Educators to Increase Family Planning Uptake among Young Couples: The Malawi Male Motivator Project

Dominick Shattuck¹, Brad Kerner², Katherine Gilles³, Joshua Murphy⁴, Thokozani Ng’ombe⁵, John Bratt⁶, Greg Guest⁷
¹Family Health International, United States of America; ²Save the Children; Dshattuck@fhi.org

A06: 4
Myths and Misinformation, Factual Information, Discussion about Family Planning and Contraceptive Use in Nigeria

Muyiwà Oladosun¹, Jennifer Anyanti², Augustine Ankohm³
¹MiraMonitor Consulting Ltd., Abuja, Nigeria; ²Society for Family Health, Abuja, Nigeria; ³Population Services International, Nairobi, Kenya; fso226@yahoo.com

A06: 5
Male Partner’s Roles in Women’s Use of Emergency Contraception

Kelly L’Engle, Dawn Chin-Quee, Michele Lanham, Laura Hinson, Heather Yahdat

Family Health International, United States of America; Dshattuck@fhi.org

B06: Contraception and Abortion I

Time: Tuesday, 17 November 2009: 11:30am - 1:00pm

Location: Meera Hall

Session Chair: Louise Lee-Jones

Session Chair: Charles Kiggundu

B06: 1
Patterns of contraceptive use and repeat abortion in Addis, Ababa Ethiopia

Ndola Prata¹, Martine Holston², Yilma Melkamu³, Tesfaye Endrias⁴, Lenesse Gobu⁵
¹Bixby Center for Population, Health, and Development, University of California, Berkeley; ²Venture Strategies for Health and Development, United States of America; ³School of Public Health, Addis Ababa University, Ethiopia; ⁴Venture Strategies for Health and Development/DKT Ethiopia, Addis Ababa, Ethiopia; ⁵mholston@venturestrategies.org

B06: 2
Factors associated with induced abortion among women aged 15-49 years in Hohoe district of Ghana

Easmon Otupiri¹, Charity Vivian Mote², Roderick Larsen-Reindorf³, Enestina Ofioriwa Akuwah⁴
¹Kwame Nkrumah University of Science and Technology-School of Medical Sciences, Ghana; ²Komfo Anokye Teaching Hospital; ³Ghana Health Service; ⁴easmono@yahoo.com

B06: 3
Motivations and obstacles to use of abortion and contraceptive services in Ukraine

Rachel Louise Criswell

Fulbright Ukraine; rachelcriswell@gmail.com

B06: 4
Contraception and Abortion in Zanzibar, Tanzania

Alison Holt Norris, Michelle J Hindin

Johns Hopkins Bloomberg School of Public Health, United States of America; anorris@aya.yale.edu

C06: Franchising FP Services

Time: Tuesday, 17 November 2009: 11:30am - 1:00pm

Location: Albert Hall
D06: FP and Maternal Child Health Outcomes

**Time:** Tuesday, 17 November 2009: 11:30am - 1:00pm  
**Location:** Victoria Ballroom

**Session Chair:** Monica Kerrigan  
**Session Chair:** Ismail Ndifuna

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**D06: 1**  
**The Contribution of Family Planning to Reducing Maternal Mortality**  
*John A. Ross*, Ann Blanc

1Futures Group International, United States of America; 2Engender Health, United States of America; JRoss@FuturesGroup.com

**D06: 2**  
**Influence of Family Size, Household Food Security Status and Child Care Practices on the Nutritional Status of Under-five Children in Ile-Ife, Nigeria.**  
*Ajao Kayode Oluwasegun, E.O. Ojoelitimi*

Obafemi Awolowo University, Ile-Ife, Nigeria; solaajao2000@yahoo.com

**D06: 3**  
**The Effects of birth spacing on infant and child mortality and on pregnancy outcomes in Abnoub District, Rural Assiut, Upper Egypt**  
*Etemad El-Sherif, MH Gayed, Ali Zarzour, Kawthar Fadel*

Assiut University, Egypt; etemadelshreef@yahoo.com

**D06: 4**  
**Towards Healthy Timing and Spacing of Pregnancies: Postpartum Family Planning- Behavior of Women in rural Jimma, South West Ethiopia**  
*Yohannes Wade*

Jimma University, Ethiopia; yohannes.dibaba@ju.edu.et

**D06: 5**  
**Systematic Review of Childbearing Patterns and Maternal Mortality**  
*Wei Huang, Carine Ronsmans*

London School of Hygiene and Tropical Medicine, United Kingdom; wei.huang@lshtm.ac.uk

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**E06: Interactions: FP and the Environment**

**Time:** Tuesday, 17 November 2009: 11:30am - 1:00pm  
**Location:** Regal Hall

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**E06: 1**  
Integration with marine conservation enhances the acceptability and use of family planning in the Philippines  
*Joan Castro*  
PATH Foundation Philippines, Inc.; Linda.Bruce@crc.uri.edu

**E06: 2**  
Integration with marine conservation improves access to family planning for traditional Muslim and semi-nomadic communities on the Kenyan border with Somalia  
*Abdiwahab Elmoge Ahmed*, Sam Mwachui1, *Sam Weru*, Judy Oglethorpe2, Cara Honzak3, Terri Lukas4

1WWF-Kenya; 2WWF-USA; 3Linda.Bruce@crc.uri.edu

**E06: 3**  
Population, Health, and Environment in Uganda: Bwindi Impenetrable National Park Case Study  
*Gladys Kalema-Zikusoka*, Lynne Gaffkin

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F06: Contraceptive Practice in Uganda

*Time*: Tuesday, 17 November 2009: 11:30am - 1:00pm  
*Location*: New Hall #1

**Session Chair**: James Gribble  
**Session Chair**: Joseph Konde-Lule

**F06: 1**

Providers Knowledge, Attitudes, Practice and Competencies for the provision of Post-Abortion Services and Contraception in six districts in Uganda  
*Janet Adongo*

Mariestopes Uganda, Uganda; janet.adong@mariestopes.or.ug

**F06: 2**

Trends in Unmet Need and Demand for Family Planning in Uganda  
*Shane Khan*, Janet Adongo*, Sarah E.K. Bradley*, Joy Fishel*, Vinod Mishra*

1United Nations Children's Fund, Panama; 2ICF Macro, United States of America; vinod.mishra@macrointernational.com

**F06: 3**

Knowledge and Utilization of Family Planning Among Women of Reproductive Age in Northern Uganda  
*Frederick Kinto Mubiru, Jimmy Odong*

Marie Stopes Uganda, Uganda; fred.mubiru@mariestopes.or.ug

**F06: 4**

Trends in Modern Contraceptive Prevalence Rate among Currently Married Women in Uganda: 1988-2006  
*Joseph Matovu*

Makerere University School of Public Health, Uganda; jmatovu@musphdc.ac.ug

G06: Emergency Contraception: Prospects and Practice

*Time*: Tuesday, 17 November 2009: 11:30am - 1:00pm  
*Location*: New Hall #2

**Session Chair**: Susan F. Newcomer  
**Session Chair**: Josaphat Byamugisha

**G06: 1**

L’introduction de la contraception d’urgence (CU) en milieu scolaire permet‐elle l’adoption de comportements à moindre risque en matière de sexualité ? Etude pilote dans une structure scolaire de Guédiawaye (Dakar – Sénégal)  
*Mohamed Diadhiou*, Thierno Dieng*, Fatou Bintou Mbou*, Youmané Faye*, Jill Keesbury*, Jean Charles Moreau*

1Centre Regional de Formation et de Recherche en Santé de la Reproduction, Senegal; 2Population Council; diadhioumohamed@yahoo.fr

**G06: 2**

Understanding Supply Chain Barriers to Emergency Contraception in South Africa  
*Priya Nanda*

ICRW, India; pnanda@icrw.org

**G06: 3**

Dispensing Practices of Pharmacists relating to Emergency Contraceptive Pills in Ibadan and Lagos Metropolis Nigeria  
*Okunke Omotosho*

College of medicine University of Ibadan, Nigeria; tosokunle@yahoo.com

**G06: 4**

A preference for emergency contraception: The case of emergency contraceptive pill use by private sector clients in Ghana  
*Dawn Chin‐Quee, Kelly L’Engle*

Family Health International, United States of America; DChin‐Quee@FHI.org

**G06: 5**

Use of Emergency Contraception among Married and Unmarried Women Aged 18‐30 in Three Kenyan Cities  
*Gwendolyn Tate Morgan*

African Population and Health Research Center, Kenya; gmorgan@aphrc.org

A07: National FP Policy and Advocacy I

*Time*: Tuesday, 17 November 2009: 2:00pm - 3:30pm  
*Location*: Sheena Hall

**Session Chair**: Sahlu Haile
A07: 1
Helping Malian Parliamentarians Bridge the Gap Between Legislation and Implementation
Modibo Maiga1, Honorable Fanta Mchantchi Diarra2
1Futures Group International, Mali; Health Policy Initiative; 2Malian Parliament; mmaiga@futuresgroup.com
A07: 2
Repositioning Family Planning in Rwanda: How a Taboo Topic Became Priority Number One, and a Success Story
Laura Hoemeke1, Julie Solo2, Sara Stratton3, Emile Sempabwa4
1IntraHealth International, Rwanda; 2Independent Consultant; lhoemeke@intrahealth.org
A07: 3
The Success Story of Implementing Best Practices in Kenya
Violet Anyanga Bukusi1, Maureen Kuyoh2, Marsden Solomon3, Anne Njeru4, Colette Obunga-Allo5
1Family Health International, Kenya; 2Division of Reproductive Health, Ministry of Public Health & Sanitation; 3Futures Group; vbukusi@fhi.org
A07: 4
Three family planning policy options in low resource settings – the case of Niger
Malcolm Potts, Martha Campbell, Virginia Gidi
UC Berkeley, United States of America; paigepassano.bixby@gmail.com

B07: Contraception and Abortion II

Time: Tuesday, 17 November 2009: 2:00pm - 3:30pm
Location: Meera Hall

Session Chair: Getachew Bekele
Session Chair: Faujdar Ram

B07: 1
Contraceptive counseling and use after second trimester abortion in South Africa
Daniel A. Grossman1, Naomi Lince2, Jane Harries3, Debbie Constant4, Marijke Alblas5, Kelly Blanchard6
1Ibis Reproductive Health, United States of America; 2Ibis Reproductive Health, South Africa; 3Women’s Health Research Unit, University of Cape Town; 4Independent consultant; dgrossman@ibisreproductivehealth.org
B07: 2
A comparison of induced abortion, spontaneous abortion, and ectopic pregnancy gynecology patients in Ghana
Hilary Megan Schwandt1, Andrea Creanga2, Richard Adanu3, Kwabena Danso1, Tsiri Agbenyega3, Michelle Hindin4
1Johns Hopkins Bloomberg School of Public Health, United States of America; 2University of Ghana, Korle Bu Teaching Hospital; Accra, Ghana; 3Kwame Nkrumah University of Science and Technology School of Medical Sciences; Kumasi, Ghana; hschwand@jhsph.edu
B07: 3
Characteristics of women seeking abortion-related services in Addis Ababa, Ethiopia
Yilma Melkamu1, Tesfanesh Belay2, Ndola Prata3, Martine Holstog4, Tesfaye Endrias5, Lense Gobu6
1School of Public Health, Addis Ababa University, Addis Ababa, Ethiopia; 2Venture Strategies for Health and Development/DKT Ethiopia, Addis Ababa, Ethiopia; 3The Bixby Center for Population, Health and Sustainability, School of Public Health University of California, Berkeley, United States; 4Venture Strategies for Health and Development, United States; mhholst@venturestrategies.org
B07: 4
Improving Quality of Abortion Services in Vietnam
Phuong Nguyen1, Ton Van der Velden, Ngo Thuy Nga2
Pathfinder International Vietnam, Viet Nam; npvuong@pathfind.org
B07: 5
Addressing Morbidity and Mortality from Unsafe Abortion: Assessment of Safe Abortion and Contraceptive Service in Ethiopia
Tibeu Alemayehu1, Joan Healy2, Karen Otsea3, Selamawit Dagne4, Janie Benson1
1Ipas (Ethiopia), Ethiopia; 2Independent Consultant; 3TRHB; alemayehut@ipas.org

C07: FP Financing

Time: Tuesday, 17 November 2009: 2:00pm - 3:30pm
Location: Albert Hall

Session Chair: Susan Mpanga Mukasa
Session Chair: Alexandra Ruth Todd-Lippock

C07: 1
Global Fund Financing of Condoms and Contraceptives for Reproductive Health Commodity Security
Nadja Olson1, Dr. Fidele Ngabo2
1USAID | DELIVER PROJECT, United States of America; 2Rwanda Ministry of Health; nolson@jsi.com
C07: 2
Vertical Provisioning of Family Planning to Rural Communities—Time for a Rethink?
Gopi Gopalakrishnan1, Karen Pak Oppenheimer2
1World Health Partners, India; 2Venture Strategies for Health and Development, USA; gopi@dktinternational.org
C07: 3
D07: Addressing the FP Needs of People Living with HIV I

**Time:** Tuesday, 17 November 2009: 2:00pm - 3:30pm  
**Location:** Victoria Ballroom

**Session Chair:** Juliana Lunguza  
**Session Chair:** Lana Rae Dakan

**D07: 1**

**Improving Family Planning Choices for People Living with HIV in Zambia**  
Uttara Bharath Kumar1, Peter Chabwela2, Carol Underwood3, Lynn Lederer4, Hilda Banda5, Jane Brown6  
1Health Communication Partnership Zambia; 2Johns Hopkins University Bloomberg School of Public Health, Center for Communication Programs; uttarabk@hdp.org.zm

**D07: 2**

**Sexual and reproductive health needs and preferences of people living with HIV/AIDS (PLWHA) in Southern Nations Nationalities and Peoples Region (SNNPR)**  
Assefa Seme Deresse7, Kekebe Debeko8  
7SPH Addis Ababa University, Ethiopia; 8SNN Regional Health Bureau; assefaseme@gmail.com

**D07: 3**

**Harm-reduction applied to reproductive health counseling for HIV-affected couples who choose to conceive children.**  
Lynn T. Matthews1, Angela Kaida2, Christina Psaros3, David R. Bangsberg4,5,6  
1Beth Israel Deaconess Medical Center; Boston, MA; 2University of British Columbia; Vancouver, CA; 3Massachusetts General Hospital; Boston, MA; 4Harvard Initiative for Global Health; Boston, MA; 5The Ragon Institute; Boston, MA; 6ltmatthe@bidmc.harvard.edu

**D07: 4**

**Factors Influencing Contraceptive Choice and Discontinuation Among HIV-Positive Women in Rio De Janeiro, Brazil**  
Monica S. Malta1, Catherine S. Todd2, Mark A. Stibich3, Thais Garcia4, Diego Pacheco1, Francisco I. Bastos5  
1Oswaldo Cruz Foundation, Brazil; 2Columbia University, United States of America; 3Xenex Technologies, United States of America; cst2121@columbia.edu

**D07: 5**

**Factors Influencing Contraceptive Choice and Discontinuation Among HIV-Positive Women in Kericho, Kenya**  
Kennedy Imbuki1, Catherine S. Todd2, Mark A. Stibich3, Douglas N. Shaffer4, Samuel K. Sine5  
1Walter Reed Project Program, Kenya; 2Columbia University, United States of America; 3Xenex Technologies, United States of America; cst2121@columbia.edu

E07: Matching FP/RH Services to Unmet Needs

**Time:** Tuesday, 17 November 2009: 2:00pm - 3:30pm  
**Location:** Regal Hall

**Sponsor:** Jhpiego

**E07: 1**

**The Case for PPIUD-Addressing Demand for Long Term Methods in Kenya and India**  
Jeffrey Smith, Joygrace Muthoni, Vinita Das  
Jhpiego, United States of America; rlu@jhpiego.net

**E07: 2**

**Integrating Family Planning into Essential Maternal and Newborn Care in Northern Nigeria**  
Emmanuel Otolorin Otolorin, Samaila Yusuf, Elaine Charurat, Catharine McKaig  
Jhpiego; rlu@jhpiego.net

**E07: 3**

**Meeting the RH Needs of the Marginalized Urban Population in Kenya**  
Pamela Lynam, Jane Otai, Stuart Merkel, Daniel Nguku  
Jhpiego, United States of America; rlu@jhpiego.net

F07: Service Delivery for Injectables, Implants, and Oral Contraception

**Time:** Tuesday, 17 November 2009: 2:00pm - 3:30pm  
**Location:** New Hall #1
Session Chair: Angela Akol
Session Chair: Sheila Nyawira Macharia

F07: 1
Assessment of Implant removal practices in Ethiopia: Early Assessment in Ethiopia
Tamrat Assefa1, Atle Bahiru1, Markus Steiner1, Atekessie Meles2, Tsegaye Asres2, Francesca Stuer3, Grethe Peterson4
1Family Health International/Ethiopia, Ethiopia; 2Family Guidance Association of Ethiopia; 3Family Health International, USA; 4Marie Stopes International, Ethiopia; TAssefa@ghi.org.et

F07: 2
Tasking shifting: The case of implants in Kenya
Janet Wasiche1, Marsden Solomon2, Maureen Kuyoh3
1Ministry of Health, Kenya, Kenya; 2Family Health International, Kenya; jwasiche2004@yahoo.com

F07: 3
Bringing their method of choice to rural women: Community based distribution of injectable contraceptives in Tigray, Ethiopia
Ndola Prata1, Amanuel Gessessew2, Alice Cartwright3, Martine Holston4, Deborah Karasek5, Malcolm Potts6
1Bixby Center for Population, Health, and Development, University of California, Berkeley; 2Mekele University, College of Health Science, Mekele, Ethiopia; 3Venture Strategies for Health and Development, United States of America; mholston@venturestrategies.org

F07: 4
Addressing unmet need for family planning in Nigeria through a comprehensive package of services
Bridgit Mary Adamou, Fatima Bunza, Abubakar Izge, Kemi Ayanda
Pathfinder International, United States of America; badamou@pathfind.org

G07: Service Provision Assessments to Strengthen FP Programs

Time: Tuesday, 17 November 2009: 2:00pm - 3:30pm
Location: New Hall #2
Sponsor: Macro International

G07: 1
Missed opportunities: Monitoring contraceptive supplies and stockouts
Paul Ametepe
Johns Hopkins Center for Communication Programs; Alfredo.fort@macrointernational.com

G07: 2
Measuring quality of family planning services using Services Provision Assessment surveys
Rathavuth Hong1, Alfredo Fort2
1Demographic and Health Surveys at ICF Macro International, United States of America; 2Demographic and Health Surveys, PATH; Alfredo.fort@macrointernational.com

G07: 3
Common National and Subnational Flaws in Management Practices of Family Planning Services in Africa
Paul Kizito1, Alfredo Fort2
1National Advisory Council for Population and Development, Ministry of Planning, Kenya; 2Demographic and Health Surveys, PATH; Alfredo.fort@macrointernational.com

G07: 4
Support systems for maintaining or improving family planning services in Africa
Gulnara Semenova1, Frederick Katumba2, Hamdy M. Abdel Ghaffar3, Mohamed Abdel Aziz Mostafa4, Fatma El-Zanaty4
1Demographic and Health Surveys at ICF Macro International, United States of America; 2El Zanaty and Associates, Egypt, Cairo, Egypt; Alfredo.fort@macrointernational.com

P4: Poster Session 4: Contraceptive Technology, Financing and Reproductive Health Issues

Time: Tuesday, 17 November 2009: 3:30pm - 4:00pm
Location: Pre-Conference Area

P4: 1
Pattern of Contraceptive Use Among Women with Sickle Cell Disease in Ibadan, South - West Nigeria.
Michael Abiola Okunola, Adebowale Abimbola Olutayo, Titilayo Akingbola, Stella- Maris Ngozi Okonkwo, Akinlade Olawumi Adeleke
University College Hospital, Ibadan, Nigeria, Nigeria; templecity108@yahoo.com

P4: 2
Determinants of home deliveries in Tanzania: Analysis from the 2004 Tanzanian Standard Demographic and Health Survey
Bellington Vwalika
University Teaching Hospital, Lusaka, Zambia; bellingtonvwalika@rzhrg.org

P4: 3
Comparative Pharmacokinetics of Depo-Provera (Depo-Medroxy Progesterone Acetate) and generic DMPA manufactured in Pakistan
Badaruddin Abbasi
Ministry of Population Welfare, Government of Pakistan, Pakistan; badarcmc@hotmail.com
P4: 4
Risk perception limits use of modern contraception in Ga East District, Ghana
Richard N. O. Aryeetey, Agnes N. Kotoh
School Of Public Health, University of Ghana, Ghana; rmokai@yahoo.co.uk

P4: 5
Effect of Gender Composition of Surviving Children on Contraceptive Use and Method Choice in Bangladesh
S. M. Mostafa Kamal
Islamic University, Kushtia-7003, Bangladesh; kamaliubd@yahoo.com

P4: 6
Awareness and Use of Family Planning Services Among Mothers’ Group
Tej Bahadur Karki
Nepal Red Cross Society, National Headquarter, Kathmandu, Nepal; nawraj.karki@gmail.com

P4: 7
UAFC: Scaling up Female Condom Use!
Ilze Roza Smits1, Lucie van Mens2, Victoria Archibong3, Annie Michèle SALLA4
1World Population Foundation, Netherlands, The; 2Universal Access to Female Condoms Joint Programme; 3Society for Family; 4Association Camerounaise pour le Marketing Social; i.smits@wfp.org

P4: 8
New estimates on unintended pregnancy in sub-Saharan Africa and potential role of contraceptive implants to alleviate the problem
David Hubacher1, Ilgenieva Mavranezouli2, Erin McGinn3
1Family Health International, United States of America; 2University College London; 3EngenderHealth; dhubacher@fhi.org

P4: 9
Les motifs d’adhésion des hommes à la planification familiale au Bénin
Ayédé Amour Balogoun, Blou Guy Franck Ale
Population Services International (PSI), Benin; abalogoun@psibenin.org

P4: 10
Impact of the integration of Lactational Amennorhea Method within a community based maternal, neonatal and child health program
Salahuddin Ahmed1, Rashiduzzaman Shah2, Ishtiaq Mannan2, Angela Nash-Mercao3, Emma Williams1, Peter Winch2, Saifuddin Ahmed2, Ahmed Al-Kabir2, Catherine McKaig4, Abdullah Baqui1
1Johns Hopkins Bloomberg School of Public Health, Bangladesh; 2Johns Hopkins Bloomberg School of Public Health, Baltimore, MD; 3ACCESS-FP of Jhpiego; 4RTM International, Bangladesh; sahmed773@yahoo.com

P4: 11
The Influence of Birth Spacing on Child Survival Beyond Infancy in Nigeria (evidence from Nigeria Demographic and Health Survey, 2003)
Oluyomi Olatunji Alabi
Obafemi Awolowo University, Ile-Ife, Osun State, Nigeria, Nigeria; yomistorii@yahoo.com

P4: 12
Empowering Communities to respond to reproductive health, maternal mortality and mobility in Delta State, Nigeria
Ufuoma Festus Omo-Obi1, John Uche Ishiekwene2, Akporobome Ashiphe3
1Christian Aid, Nigeria, Nigeria, Nigeria; 2Deux Projects Nigeria Ltd; 3Positive Peer Club, Delta State, Nigeria; ufoatst123@yahoo.com

P4: 13
Costs and benefits: Ever used contraceptive, family size and under-5 child surviving trend in Nigeria (1990-2003 as case study).
Ayotunde Titilayo, Ojo Melvin Agunbiade, Oluyomi Olatunji Alabi
Obafemi Awolowo University, Ile-Ife, Nigeria, Nigeria; liasuyotunde@gmail.com

P4: 14
Fertility Regulation Among Women in Reproductive Age Group in Ibadan
Michael Abiola Okunola, Akinlade Olawumi Adeleke, Adebowale Obimba Oluayo, Stella- Maris Ngozi Onokwo
University College Hospital, Ibadan, Nigeria, Nigeria; templecity108@yahoo.com

P4: 15
Expanding Use of Longer term Contraceptives Methods: Reaching the rural populations using outreach interventions in a culturally sensitive communities
Kolapo Oyeniyi, Obi Olugbo, Chris Eneche, Fatima Muhammad
Society for Family Health, Nigeria; koyeniyi@sfhngigeria.org

P4: 16
Should Short Term Hormonal Methods continue dominating the contraceptive mix in Sub Saharan Africa?
Jean-Pierre Manshande1, Ioana Kruse2
1Population Services International (PSI), Madagascar; 2Johns Hopkins University, School of Public Health; jmanshande@psi.org

P4: 17
The Supply-Demand-Advocacy FP Program Model at Work: Case studies from Kenya and Azerbaijan
Holly J. Connor, Erin K. McGinn, Mavjudat Babamuradova, Frederick Ndede
EngenderHealth, United States of America; emcgin@engenderhealth.org

P4: 18
Profiles of Male and Female Consistent Condom Users in Nairobi, Kenya
Gwendolyn Tate Morgan
African Population and Health Research Center, Kenya; gmorgan@aphrc.org

P4: 19
Predictive Factors for Contraceptive Counseling and Uptake after Post-abortion Care at the Private Providers Health Facilities in Western Kenya

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**A08: National FP Policy and Advocacy II**

**Time:** Tuesday, 17 November 2009: 4:00pm - 5:30pm  
**Location:** Sheena Hall

**Session Chair:** Harry Jooosey  
**Session Chair:** Anthony Mbonye

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**A08: 1**

**Effort Ratings for National Family Planning Programs**

*Ellen Smith, John Ross, Aditi Krishna*

Futures Group International, United States of America; esmith@futuresgroup.com

**A08: 2**

**Family planning champions: Harnessing the innovative advocate**

*Tricia Petruney, Kate H Rademacher, Jason B Smith*

Family Health International, United States of America; tpetruney@fhi.org

**A08: 3**

**Advocating for Innovation: Community-based Provision of Injectable Contraception in Africa - Getting Past ‘No Way!’**

*Kirsten Krueger, Morissa Malkin, Crystal Dreisbach, Amanda Abbott*

Family Health International, United States of America; mmalkin@fhi.org

**A08: 4**

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

*Anne Jorgensen*, *Anita Bhuyan*, *Suneeta Sharma*, *Lucia Merino*, *Gadde Narayana*, *Himani Sethi*, *Claudia Quinto*, *Marisela de al Cruz*, *Alexia Alvarado*, *Fernando Cano*, *Imelda Zosa-Farani*

1 Futures Group International/Health Policy Initiative, Task Order 1, United States of America; 2 Centre for Development and Population Activities (CEDPA)/Health Policy Initiative, Task Order 1; 3 Futures Group International, Guatemala; 4 Futures Group India; 5 Futures Group International, El Salvador; abhuyan@futuresgroup.com

**A08: 5**

**Implementing Sustainable Solutions to Enhance Access to Family Planning among the Poor in Kenya**

*Owino Wasunna, Suneeta Sharma*

USAID Health Policy Initiative, Kenya; wowino@futuresgroup.com
B08: Operations Research on Postpartum FP

**Time:** Tuesday, 17 November 2009: 4:00pm - 5:30pm  
**Location:** Meera Hall

**Sponsor:** Population Council

**B08: 1**
Delivering FP information and services to postpartum women in clinic-based settings: A review of evidence from operations research

Ricardo Vernon, Ian Askew

1Investigacion en Salud y Demografia (INSAD), Mexico; 2Population Council, Kenya; cwarren@popcouncil.org

**B08: 2**
Increasing use of LAM and postpartum contraception through a community-based intervention among low parity women in Uttar Pradesh, India

M.E. Khan, Mary Sebastian
Population Council, India; cwarren@popcouncil.org

**B08: 3**
Strengthening postpartum family planning services to increase use of contraception in rural Egypt

Nahla Abdel-Tawab
Population Council, Egypt; cwarren@popcouncil.org

**B08: 4**
Postpartum family planning in a high HIV environment: evidence and challenges

Charlotte E Warren, Rachel Shongwe, Thato Tsukulu
1Population Council, Kenya; 2Central Statistics Office Swaziland; 3Planned Parenthood Association Lesotho; cwarren@popcouncil.org

C08: Public-Private Partnerships for Successful FP Financing

**Time:** Tuesday, 17 November 2009: 4:00pm - 5:30pm  
**Location:** Albert Hall

**Session Chair:** Phil Harvey
**Session Chair:** Paul Hamilton

**C08: 1**
Improving Social Marketing of Female Condom in Nigeria: Expanding level of coverage and quality of coverage

Samson Babatunde Adebayo, Richard Fakolade, Victoria Archibong, Jamilah Mohammed-Jantabo
Society for Family Health, Nigeria; sadebayo@sfh.org

**C08: 2**
Increasing Availability of Intrauterine Contraceptive Device Within A Social Franchised Network Through Use Of Reproductive Health Days

Jayne Rowan, Nyo Nyo Minn, Dan Rosen
1PSI/Myanmar, Myanmar; 2PSI; jrowan@psimyanmar.org

**C08: 3**
Total Market Approach to Improving Family Planning Access in the Republic of Georgia

Nino Berdzuli, Nancy Harris, Kartlos Kankadze
1John Snow, Inc, United States of America; 2John Snow, Inc, United States of America; 3Healthy Women in Georgia Program, JSI Research & Training Institute; nberdzuli@jsi.com

**C08: 4**
Experience of Oromia Development Association on Cost Sharing

Mulugeta Hawas, Tessema Firdissa
Oromia Development Association, Ethiopia; oda-cbrh@ethionet.et

D08: Addressing the FP Needs of People Living with HIV II

**Time:** Tuesday, 17 November 2009: 4:00pm - 5:30pm  
**Location:** Victoria Ballroom

**Session Chair:** Lilly Memory Banda-Maliro
**Session Chair:** Alice Auma Olawo

**D08: 1**
Effect of hormonal contraceptive use on time-to-death in female incident HIV seroconverters in Rakai, Uganda

Chelsea Bernhardt Polis, Ron H Gray, Tom Lutalo, Fred Nalugoda, David Serwadda, Godfrey Kigozi, Joseph Kagaayi, Noah Kiwanuka, Nelson Sewankambo, Michael Z. Chen, Maria Wawer
1Johns Hopkins Bloomberg School of Public Health, United States of America; 2Rakai Health Sciences Program, Uganda Virus Research Institute, Entebbe, Uganda; 3Institute of Public Health, Makerere University, Kampala, Uganda; cpolis@jhsph.edu

**D08: 2**
Predictors of Pregnancy in Microbicide Trials

Vera Halpern, Che-Chin Lie, Fernand Guédou, Florence Mirembe, Christine Mauck, Roshini Govinden, Donna McCraraer, Orikomaba Obunge, Folasade Ogunsola

Role of Menstruation in Contraceptive Choice Among HIV-Positive Women in Soweto, South Africa
Fatima Laher1, Catherine S. Todd2, Mark A. Stibich3, Rebecca Phofa4, Xoliswa Behane1, Loreto Mohapi1, Glenda Gray2
1Perinatal HIV Research Unit, Witwatersrand University, South Africa; 2University of Port Harcourt Teaching Hospital, Port Harcourt, Nigeria; 3College of Medicine, University of Lagos, Lagos, Nigeria; vhalpern@fhi.org

Peri-conception pre-exposure prophylaxis for sero-discordant couples who choose to conceive children in resource-limited settings.
Lynn T. Matthews1, David R. Bangsgberg1,2
1Beth Israel Deaconess Medical Center; Boston, MA; 2Harvard Initiative for Global Health; Boston, MA; 3Massachusetts General Hospital; Boston, MA; 4The Ragon Institute; Boston, MA; ltmattth@bidmc.harvard.edu

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
Mantshi Elizabeth Teffo-Menziwa1, Wilson Liambila2, Saqa Mullick3, Doctor Khoza4, Ian Aske4, Edwin Maroga2
Population Council, South Africa; mmenziwa@popcouncil.org

E08: Contraceptive Failure, Unwanted Pregnancy and EC

Time: Tuesday, 17 November 2009: 4:00pm - 5:30pm  
Location: Regal Hall

Sponsor: Institut National d’Etude Démographiques

E08: 1
Gender relations and unintended pregnancies in Ouagadougou: are men a problem or a solution?
Clementine Rossier1, André Soubeiga2, Nathalie Sawadogo3
1Institut National d’Etude Démographiques, France; 2Université de Ouagadougou, Ouagadougou, Burkina Faso; 3Université Catholique de Louvain, Belgium; clementine.rossier@ined.fr

E08: 2
Contraceptive difficulties in Africa: what role for emergency contraception?
Nathalie Bajo1, Agnès Adjagnagbo2, Michéle Ferrand3, Agnès Guillaume2, Clémentine Rossier4, Maria Texeira5
1Institut National de la Santé et de la Recherche Médicale, Paris, France; 2Institut de Recherche pour le Développement, Marseille, France; 3Centre National de la Recherche Scientifique, Paris, France; 4Institut National d’Etudes Démographiques, Paris, France; 5Institut National de la Santé et de la Recherche Médicale, Paris, France; clementine.rossier@ined.fr

E08: 3
Providers’ perspective on emergency contraception and opportunities for enhancing access in Ghana, Burkina Faso and Morocco
Susannah Mayhew
London School of Hygiene and Tropical Medicine, United Kingdom ECAF team; clementine.rossier@ined.fr

E08: 4
Entry into sexuality and access to contraception: Comparing Morocco and Senegal
Agnès Adjagnagbo1, Fatima Bakass2, Pierrette Koné3
1Institut de Recherche pour le Développement, Marseille, France; 2Institut National de Statistiques et d’Economie Appliquée, Rabat, Morocco; 3Santé Reproductive et Genre, Dakar, Senegal; clementine.rossier@ined.fr

F08: Harnessing Social Institutions to Support FP

Time: Tuesday, 17 November 2009: 4:00pm - 5:30pm  
Location: New Hall #1

Session Chair: John Goodhart Cleland  
Session Chair: Linda Cahaelen

F08: 1
Engaging Muslim Leaders in Support of Family Planning in Tanzania
Gregory Kamugisha
Futures Group International, Tanzania/Health Policy Initiative, Tanzania; GKamugisha@futuresgroup.com

F08: 2
Improved Sexual Behavior among Young Women: The Women-LEEP Experience
Oghenefego Onome Isikwenu1, Mary James1, Bridget Anyafulu1, Epha Ikoghoode-Aikpitany1, Tunde Akintoroye3
1Inspiro Communications & Media, Nigeria; 2Oxfam Australia; 3Int’l Centre for Women Empowerment & Child Dev; 4Girl Power Initiative, Asaba; 5PET NYSC, Delta state; fgoobu@yahoo.com

F08: 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
Amos Kankponang Laar
G08: Effective Programming and Service Delivery III

Time: Tuesday, 17 November 2009: 4:00pm - 5:30pm
Location: New Hall #2
Session Chair: Susan Krenn
Session Chair: Beatrice Atieno Ochieng

G08: 1
Campagne Nationale en Faveur de la Planification Familiale au Mali : Contribution au Repositionnement de la Planification Familiale
Abdourhamane Maiga, Diallo Haleimatou Maiga, Timothée Gandaho, Lisa Nichols, Keita Binta, Doucoure Arkia Diallo, Konate Ramata Fomba
Programme Santé USAID/ATN Plus, Mali; amaiga@atnsante.org

G08: 2
Family Planning Implementation Teams: Building Sustainable Community Ownership in Rural Uganda
Joan Patterson†, Paige Anderson Bowen‡, Heather Lukolyo§, Laura C. Ehrlich¶, Diana K. DuBois‖
†Minnesota International Health Volunteers, United States of America; ‡University of Minnesota School of Public Health, United States of America;¶lehrlich@mihv.org

G08: 3
The Confiance Family Planning Network: using a social marketing network to re-establish FP in a post-conflict DRC
Jamaica Corker
Population Services International, United States of America; jcorker@psicongo.org

G08: 4
Policy imperatives for systems oriented approaches to scaling up: Case example of taking a new family planning method to national scale
Susan Igras, Rebeca Lundgren, Marie Mukubatsinda, Arsene Binanga, Foufa Toure
Institute for Reproductive Health/Georgetown Univ, United States of America; smi6@georgetown.edu

G08: 5
Integrated Family Health Program Helps Family Planning Compliance Among Women Using After the First Child.
Tawhida Khalil, Douglas Storey, Don Hess
JHU SPH, Egypt; tkhalil@jhhcp-eg.org

Wednesday, 18 November 2009

Plenary

Time: Wednesday, 18 November 2009: 8:30am - 10:30am
Location: Victoria Hall

Summary of the First Two Days of the FP Conference
Ward Cates, President, Family Health International

IBP Principles and Practice, and Country Experience
Josephine Kibaru, Head Division of Reproductive Health, Ministry of Health Kenya

How Change Agents Make a Difference
TBD

New Technologies for FP Advocacy
Jotham Musinguzi, Director, Partners in Population and Development, Africa Regional Office

A09: Mobilizing Commitment and Funding for FP

Time: Wednesday, 18 November 2009: 10:30am - 11:45am
Location: Sheena Hall
Session Chair: Pape A Gaye

A09: 1
The Fall and Rise of the Green Star: An analysis of effects of program restructuring to the weakening of the Tanzania National Family Planning Program and advocacy efforts to revive it.
Christine Lasway†, Maurice Hiza‡
†Family Health International, Tanzania; ‡Tanzania Ministry of Health, Reproductive and Child Health Section.; clasway@fhi.org

A09: 2
B09: Leading and Managing for Results in FP

Time: Wednesday, 18 November 2009: 10:30am - 11:45am
Location: Meera Hall
Session Chair: Timothy R. Allen

B09: 1
Makerere University’s Investment in Pre-service Action-Oriented Leadership and Management Training: What are the Lessons for Family Planning?
Mors Mansour¹, Stephen Kijjambu²
¹Management Sciences for Health (MSH), United States of America; ²Dean of School of Medicine, Makerere University, College of Health Sciences; mmansour@msih.org

B09: 2
Improving leadership and management at the front line to scale up and accelerate family planning results
Joan Mansour¹, Juliana Bantambya²
¹Management Sciences for Health, United States of America; ²EngenderHealth /ACQUIRE, Tanzania; jmansour@msh.org

B09: 3
Developing a Framework and Approach for Measuring Success in Repositioning Family Planning
R. Scott Moreland, Nicole R Judice
Futures group, United States of America; smoreland@futuresgroup.com

B09: 4
Scaling Up Proven Public Health Interventions through a Locally Owned and Sustained Leadership Development Program in Rural Upper Egypt
Abdo Hasan El Swasy
Ministry of Health and Population, Egypt; abdo_alswasy@hotmail.com

C09: Access to RH Essential Medicines and Commodities: The Missing Link to Improving RH

Time: Wednesday, 18 November 2009: 10:30am - 11:45am
Location: Albert Hall
Session Chair: Maggie Usher-Patel

C09: 1
Expanding Global Access to Emergency Contraception: Challenges and Lessons from the Public and Private Sector
Elizabeth Westley
International Consortium for Emergency Contraception, United States of America; ewestley@fcimail.org

C09: 2
Policy and Advocacy Initiatives for Reproductive Health Commodity Security
Jotham Musinguzi
Partners in Population and Development Africa Regional Office, Uganda; jmusinguzi@ppdsec.org

C09: 3
Public Private Partnerships in Supply Chain Management: Lessons for Family Planning Programs
Alexis Heaton¹, Christine Fullmer²
¹John Snow, Inc., United States of America; ²PHD, a division of the Fuel Group; aheaton@jsi.com

C09: 4
UNFPA-HQ Collaborative Initiative to Review the Current Status of Access to a Core Set of Critical, Life-Saving Maternal/Reproductive Health Medicines in Selected Countries (Laos, Nepal, Philippines, Mongolia, & Ethiopia)
Ahmed Kabir³, Helene Moller²
³UNFPA; ²WHO/Geneva; kahmed@unfpa.org
D09: Promoting Access and Affordability of FP

Time: Wednesday, 18 November 2009: 10:30am - 11:45am  
Location: Victoria Ballroom  
Session Chair: Angela Akol

D09: 1
What type of programmes have been successful in increasing access of marginalized groups to FP/SRH?

* Nuryie Ortayli  
UNFPA, United States of America; ortayli@unfpa.org

D09: 2
Integrating Equity Goals and Approaches into Policies, Plans, and Agendas

* Wasunna Owino, Suneeta Sharma  
Futures Group International, United States of America; ssharma@futuresgroup.com

D09: 3
Community-Based Access to Injectables: Policy Changes around Task-Sharing

* Anthony Mbonye, Shawn Malarcher  
1Uganda Ministry of Health; 2Consultant; akmbonye@yahoo.com

D09: 4
Improving Access to and Affordability of Family Planning Services

* Nancy McGirr, Shuvi Sharma, Nidhi Chaudhary  
Futures Group, United States of America; nmcgirr@futuresgroup.com

E09: Working Together to Integrate FP into Other Essential Services

Time: Wednesday, 18 November 2009: 10:30am - 11:45am  
Location: New Hall #1  
Session Chair: Mario Festin

E09: 1
Sexual Reproductive Health and Rights (SRHR), HIV/AIDS Linkages and Integration Study in Uganda

* Olive Sentumbwe Mwigisa, Rita Nawada, Rosemary Kindynomunda, Dr. Esiru, Collins Tusingirwe, Beatrice Crahay  
1World Health Organisation, Uganda; 2UNFPA; 3Ministry of Health; sentumbweo@who.int

E09: 2
Kenya's National Strategy on integrating RH and HIV: Main Features, Process followed in its development, Lessons Learned and Policy Implications

* Margaret Gitau, Bartiol Kigen  
National AIDS and STIs Control Programme (NASCOP) – Ministry of Health, Kenya; gitau@aidskenya.org

E09: 3
Integrating Healthy Timing and Spacing of Pregnancy into Child Health Services in Rwanda: an essential child survival intervention

* Issakha Diallo, Gloria Ekpo, Naomi Brill Skena  
1Management Sciences for Health, United States of America; 2BASICS; hakhter@msh.org

E09: 4
Implementing a Sustainable Integrated MCH/FP/RH Model

* Nagwa Samir, Lynne Morin  
Pathfinder International, Egypt; LMorin@takamol.org

F09: Preparing the Next Generation of FP Providers

Time: Wednesday, 18 November 2009: 10:30am - 11:45am  
Location: New Hall #2  
Session Chair: Rosemary Kamunya

F09: 1
Addressing Gaps in Family Planning Education through Building the Capacity of Pre-service Tutors

* Helen Lugina, Sheillah Matinthur, Nina Frankel, Holley Stewart  
1East, Central and Southern African Health Community, Tanzania; 2Capacity Project; 3Africa’s Health in 2010; helugina@ecsa.or.tz

F09: 2
Introduction of Long Term Family Planning Methods to Address the Unmet Needs for Zambian Women

* Bernard Kasawa  
JHPIEGO Health Services and Systems Program, Zambia; kasawa2000@yahoo.com

F09: 3
Introduction of two best practices in Madagascar: lessons learned about the implementation and analysis of the project

* Jennifer L Wesson, Tara Nutley, Serge Raharison, Mackenzie Green, Ny Lova Rabenja.  
1Family Health International; 2MEASURE Evaluation; 3Madagascar Ministry of Health and Family Planning; jwesson@fhi.org
A10: Improving FP Through Communication and Client Centered Care
Time: Wednesday, 18 November 2009: 11:45am - 1:00pm
Session Chair: Gulen Arzum Ciloglu

A10: 1
Engaging Malian Religious Leaders on the Issue of Male Involvement in FP
Modibo Maiga 1, Dr. Binta Keita 2
1 Futures Group International, Mali, Health Policy Initiative; 2Malian Ministry of Health (DSR); mmaiga@futuresgroup.com

A10: 2
Designing a Family Planning Campaign for Rural Women in Zambia
Utara Bharath Kumar 1, Reuben K. Mbewe 2, Lynn Lederer 3, Faraz Naqui 2
1 Health Communication Partnership, Zambia; 2Ministry of Health, Zambia; utarabk@hcp.org.zm

A10: 3
Expanding Technical Capacity in Conflict Settings: Leveraging Networks to Strengthen FP Programs
Katie Mary Anfinson, Stephanie Weber, Melissa Sharer
American Refugee Committee, United States of America; katea@archq.org

A10: 4
Reducing Fertility in Ethiopia: Results of a Radio Serial Drama
Kriss Barker, Negussie Teferra
Population Media Center, South Africa; krissbarker@populationmedia.org

B10: Partnerships: A Powerful Force for Change
Time: Wednesday, 18 November 2009: 11:45am - 1:00pm
Session Chair: Suzanne M. Reier

B10: 1
Building consumer markets for commercially viable products: The Locon F experience
Francoise Armand, Jeffrey Barnes
Abt Associates; Francoise_Armand@AbtAssoc.com

B10: 2
Large-Scale Partnership to improve family planning acceptance and use in Mali
Arkia Doucoure - Diallo 1, Lisa Nichols 1, Binta Keita 2, Timothee Gandaho 3, Ramata Komate - Fomba 4
1 USAID Health Program for Technical Assistance Plus (ATN PLUS), Mali; 2RH Division/National Directorate of Health / Ministry of Health Mali; adoucoure@atnsante.org

B10: 3
Creating a Compendium of Best Practices: Contributions of the IBP Kenya Team
Marsden Solomon 1, Monica Wanjiru 1, Joyce Lavussa 1, Bartilol Kigen 1, Amanda Abbot 1
1Family Health International, Kenya; 2Population Council, Kenya; 3Division of Reproductive Health, Ministry of Public Health and Sanitation; 4World Health Organization, Country Office, Kenya; 5Family Health International, North Carolina; msolomon@fhi.org

B10: 4
Partnering with faith-based organizations to diminish unmet need for family planning in Rwanda
Laura Hurley, Laura Hoemeke, Suzanne Mukakabanda, Gaspard Bayigane
IntraHealth International, Rwanda; lhurley@intrahealth.org

C10: Innovations in Knowledge Sharing and Networking for FP: How to Make a Difference
Time: Wednesday, 18 November 2009: 11:45am - 1:00pm
Location: Albert Hall

C10: 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?
Tara Sullivan, Philippe LeMay, Vanessa Mitchell, Megan O’Brien
Center for Communication Programs, United States of America; plemay@jhuccp.org

C10: 2
Creating knowledge pathways to improve reproductive health
Maggie Usher-Patel 1, Megan O’Brien 2, Katie Richey 1
1 WHO, Switzerland; 2K4H/JHU/CCP; usherpatelm@who.int

C10: 3
International Association of Public Health Logisticians: Laying the Foundation for a Vibrant Online Community of Practice
Hamisu Hassan, Jennifer Antilla, Sylvia Njoroge
John Snow, Inc./ Making Medical Injections Safer (MMIS), Nigeria; hamisuhassan@yahoo.com

C10: 4
The 10 Elements of Family Planning Success: Engaging Family Planning Professionals Worldwide to Identify Factors for Success
D10: Gender and Reproductive Rights: The Foundation of Successful FP Programmes

Time: Wednesday, 18 November 2009: 11:45am - 1:00pm
Location: Victoria Ballroom
Session Chair: Janet Jackson

D10: 1
The Development and Testing of a Programming Model for Addressing the Role of Men in Family Planning
Andrew Levack, Theresa Castilla
EngenderHealth, United States of America; alevack@engenderhealth.org

D10: 2
Evidence-Based Guidelines for Addressing Adolescent Contraception in the Context of Conservatism, Poverty, and Gender-Based Violence: A Peruvian Study
Maria Ragu
Pontificia Universidad Catolica del Peru, Peru; mragu@pucp.edu.pe

D10: 3
Constructs of power and equity, and their association with contraceptive use among African men
Doris Bartel1, Rob Stephenson1, Marcie Rubardti
1CARE, United States of America; 2Emory University; dbartel@care.org

D10: 4
Promoting Reproductive Rights and Sexual and Reproductive Health of Adolescents and Youth: Lessons learned from Colombia
Lucy Wartnerberg1, Mona Kaidbey2, Ana Cristina Gonzalez2
1Unknown; 2UNFPA, United States of America; kaidbey@unfpa.org

E10: Health Systems Strengthening: What to Target for Sustainable, Quality FP Services

Time: Wednesday, 18 November 2009: 11:45am - 1:00pm
Location: New Hall #1
Session Chair: Eduard Bos

E10: 1
The contribution of the Botswana Family Planning Program to the largest fertility decline in Sub-Saharan Africa
Veronica Manana Lebur1, Shenaz El-Halabi1, Lesego Mokganya1, Samuel Mills1
1Ministry of Health, Botswana; 2World Bank; vleburu@gov.bw

E10: 2
Upazilla Health System Strengthening – A Demand Side Financing and Integrated Approach for RH services from Bangladesh
Ahmed Al Kabir
Research, Training and Management (RTM) International, Bangladesh; alkabir@rtm-international.org

E10: 3
Strengthening Family Planning and Reproductive Health Programs Through Better Health Systems
Ayman Mohsen, Barbara Seligman
Abt Associates, United States of America; barbara_seligman@abtassoc.com

F10: Addressing Youth Special Needs: Lessons Learned from Research

Time: Wednesday, 18 November 2009: 11:45am - 1:00pm
Location: New Hall #2
Session Chair: Laura Laski

F10: 1
Youths As Effective Role Models in Integrated HIV and Family Planning Program in Rural Community - Lessons learnt from a Youth FP/HIV intervention in Nwaorieubi, Imo state of Nigeria
Cornel Ekoh, Ben Ofudje, Anthony Obilor, Blessing Obasi, Oluchi Ofurum
Society for Family Health, Nigeria; Cornel316@yahoo.com

F10: 2
Reaching young mothers and young girls with postpartum family planning services in Haiti
Lucito Jeaninis1, Robin Anthony Kouyate2, Véronique Dupont1
1Jhpiego; 2Academy for Educational Development, United States of America; rkouyate@jhpiego.net

F10: 3
Qualitative Research to Improve Counseling on Dual Protection Targeting Adolescents in Dar es Salaam, Tanzania
Teresa Hoke1, Stella Mujaya1, Sebalda Leshabari1
1Family Health International, United States of America; 2School of Nursing, Muhimbili University; thoke@fhi.org
P5: Poster Session 5: Taking Knowledge to Action in FP Programming

Time: Wednesday, 18 November 2009: 1:00pm - 2:00pm
Location: Pre-Conference Area

P5: 1
Feasibility Study of Using Paramedics for Providing Emergency Contraceptive Services in India
M.E Khan, Shiv Kumar, Chander Shekhar, Mary Philip Sebastian
Population Council; mekhan@popcouncil.org

P5: 2
Social Marketing: Increasing Availability of Contraceptives among Rural Populations
Shweta Sharma, Nizamuddin Khan, Pramod Kumar Tripathi
Futures Group India, India; shsharma@futuresgroup.com

P5: 3
Local-level policy and advocacy strategies to increase access to family planning for vulnerable populations in the Dominican Republic
Jeanette del Carmen Tineo, Hannah C. Fortune-Greeley
Futures Group International; jeannette.tineo@gmail.com

P5: 4
Standard Days Method of Family Planning: Experience with Use
Samson Babatunde Adebayo, Chinazo Ujuju, Jennifer Anyanti
Society for Family Health, Nigeria; sadebayo@sfhnigeria.org

P5: 5
Addressing the Family Planning Needs of People Living with HIV in Ghana: A Community-Facility Partnership Approach.
Olivia Edem Aglah, Laura Subramanian, Nancy Russell, Jane Wickstrom, Betty Farrell, Richard Killian, Phillip Ampofo, Edward Bonku
*EngenderHealth/Quality Health Partners, Ghana; †EngenderHealth, New York; ‡Development Alternatives, Inc; oaglah@ghanaqhp.org

P5: 6
Improving Reproductive Health Medical Education in Viet Nam
Huu van Nga, Nguyen Thu Ha, Ton van der Velden, Truong Quang Vinh, Cao Ngoc Thanh
*Pathfinder International, Viet Nam; †Hue College of Medicine and Pharmacy; ‡Huu@pathfind.org

PS: 7
The Total Market Approach in Ukraine: Increasing Access with Public-Private Partnerships
Rachel Louise Criswell, Laurentiu Mihai Stan, Ola Shmanko
Together for Health; rachelscriswell@gmail.com

P5: 8
Promoting advocacy to reduce gaps: Internet-based experience
Maruan Barakat, Ana Jacinto
Pathfinder International, Mozambique; jpacca@pathfind.org

PS: 9
Does knowledge influence attitude to condom use? Observations from a nationally representative sample of Nigerian youths
Temitope Ayodele Folaromi
Obafemi Awolowo University, Nigeria; topefolaromi@yahoo.com

P5: 10
Overcoming Inertia: Translating Policies into Action in Support of Integrated Programming for Family Planning and HIV Services in Tanzania
Stella Muyaji, Anath Rwebemba, Maurice Hiza, Christine Lasway
*Family Health International, Tanzania; †Tanzania Ministry of Health and Social Welfare - National AIDS Control Program; ‡Tanzania Ministry of Health and Social Welfare - Reproductive and Child Health Service; smuyaji@fhi.org

P5: 11
The use of routine monitoring and evaluation systems to assess a referral model of family planning and HIV service integration in Nigeria
Nzapfurundi Otto Chabiku, Dorka Aw, Ogo Chukwujekwu, Usman Gwarzo, Mohammed Ibrahim, Mike Merrigan, Christoph Hamelmann
Family Health International, Nigeria, Nigeria; ochabiku@ghain.org

P5: 12
Men’s Health Kit: Increasing male involvement in reproductive health
Uttara Bharath Kumar, Faraz Naqvi, Reuben Mbewe, Lynn Lederer
*Health Communication Partnership, Zambia; †Ministry of Health, Zambia; uttarabk@hcp.org.zm

P5: 13
The myths and reality of virtual facilitation and networks
Timothy R. Allen
Management Sciences for Health, United States of America; tallen@msh.org

P5: 14
Family Planning Advocacy in Ethiopia: Experiences from the Consortium of Reproductive Health Associations
Zewditu Kebede Tesemma
Consortium of Reproductive Health Associations (CORHA), Ethiopia; zewditi@yahoocom

P5: 15
Long Acting and Permanent Family Planning Skills Training in the Pre-service Education of Midlevel Health Workers in Ethiopia
Zewditu Kebede Tesemma
Consortium of Reproductive Health Associations (CORHA), Ethiopia; zewditi@yahoocom
CB01: The Missing Link: The Management of Change to Scale Up Effective Practices

Time: Wednesday, 18 November 2009: 2:00pm - 3:30pm
Location: New Hall #1

CB02: Using FP Tools: WHO Guidance and Provider Checklists

Time: Wednesday, 18 November 2009: 2:00pm - 3:30pm
Location: New Hall #2

CB03: Scaling Up From the Start: Beginning with the End in Mind

Time: Wednesday, 18 November 2009: 2:00pm - 3:30pm
Location: New Hall #3
CB04: Reality Check: A Forecasting Tool for Evidence-Based Planning and Advocacy

*Time:* Wednesday, 18 November 2009: 2:00pm - 3:30pm  
*Location:* New Hall #4

**CB04:**

**Reality Check: A Forecasting Tool for Evidence-Based Planning and Advocacy**

John Pile  
EngenderHealth; richeyc@who.int

CB05: Tips and Tools for FP Advocacy

*Time:* Wednesday, 18 November 2009: 2:00pm - 3:30pm  
*Location:* Victoria Ballroom

**CB05:**

**Tips and Tools for FP Advocacy**

Rhonda Smith  
World Health Organization, Switzerland; richeyc@who.int

CB06: Documentation of "Practices that Make Programmes Work"

*Time:* Wednesday, 18 November 2009: 2:00pm - 3:30pm  
*Location:* Meera Hall

**CB06:**

**Documentation of "Practices that Make Programmes Work"**

Suzanne Reier  
WHO/IBP; richeyc@who.int

CB07: "Social Analysis and Action" Approach

*Time:* Wednesday, 18 November 2009: 2:00pm - 3:30pm  
*Location:* Sheena Hall

**CB07:**

**"Social Analysis and Action" Approach**

Arzum Ciloglu  
CARE; richeyc@who.int

CB08: Improving Technical Assistance with a Focus on Evidence-Based Practices

*Time:* Wednesday, 18 November 2009: 2:00pm - 3:30pm  
*Location:* Albert Hall

**CB08:**

**Improving Technical Assistance with a Focus on Evidence-Based Practices**

Nandita Thatte  
USAID; richeyc@who.int

CB09: Female Condom Programming

*Time:* Wednesday, 18 November 2009: 2:00pm - 3:30pm  
*Location:* Majestic Hall

**CB09:**

**Female Condom Programming**

Ilze Smit, Lucie van Mens, Hendrick Salla, Victoria Archibong  
Universal Access to Female Condoms Joint Programme; richeyc@who.int
PROGRAM ABSTRACTS

Monday, 16 November 2009

A01: FP and the MDGs

**Time:** Monday, 16 November 2009: 9:30am - 11:00am

A01: 1

**Achieving the Millennium Development Goals: The Contribution of Family Planning**

Rachel Sanders, Scott Moreland, Thomas Goliber

Futures Group, United States of America; rsanders@futuresgroup.com

1. Background/Significance

In September 2000, 191 nations committed themselves to the Millennium Development Goals (MDGs). For many countries, meeting these goals will be a challenge, and they will need to employ every tool at their disposal. Family planning (FP) is one of those tools, and can make a strong contribution to meeting the MDGs. In fact, to accelerate progress in achieving the MDGs, a new target was added under the maternal health goal (MDG 5) in 2007. The new target, 5b, calls for providing universal access to reproductive health services by 2015 and includes the contraceptive prevalence rate and unmet need for FP as key indicators for meeting this target.

2. Hypothesis

This analysis proposed that countries would find it easier and less costly to meet the MDGs if they invest in reducing unmet need for family planning. We tested this hypothesis using benefit-cost analysis to compare costs and benefits of investing in family planning. The analysis bolsters appeals to both economic and public health concerns, which helps broaden support for family planning among a wider range of decisionmakers.

3. Methodology

This analysis applies benefit-cost methodology to estimate the extent of the cost savings for five of the eight MDGs if countries were to invest more in family planning:

1. Achieve universal primary education
2. Reduce child mortality
3. Improve maternal health
4. Reduce the spread of infectious diseases
5. Ensure environmental sustainability

The benefit-cost study is based on selected targets of five of the eight MDGs using a modeling approach. We present two population projections—one based on stable contraceptive prevalence and the other based on meeting 2006 levels of unmet need. We then estimate the extra cost of satisfying the unmet need for family planning. Next, we discuss scenarios and cost analyses based on five MDG models in the areas of education, child survival, maternal health, malaria, and water and sanitation. Lastly, using the benefit-cost framework, we compare the costs of family planning to the reduction in costs of meeting the five MDG targets. This analysis was completed for 17 African countries (Burkina Faso, Cameroon, Chad, Ethiopia, Ghana, Guinea, Kenya, Madagascar, Malawi, Mali, Niger, Nigeria, Rwanda, Senegal, Tanzania, Uganda, and Zambia).

4. Findings

Meeting unmet need for FP would result in fewer unintended pregnancies, leading to a smaller population in need of the services required to achieve the MDGs and, consequently, would reduce the costs for meeting the MDGs. Analysis of the 17 countries in Africa showed that for every dollar invested in FP, there would be a return of between $2 and $7, considering indicators for the five MDGs listed earlier. The largest savings would be in the areas of primary education and provision of maternal health services.

FP also helps to reduce the number of high-risk pregnancies, thereby reducing the levels of maternal and infant mortality associated with risky pregnancies. For example, the study shows that addressing unmet need in Uganda could be expected to avert nearly 6,000 maternal deaths and more than 450,000 child deaths by 2015.

5. Knowledge contribution

In sum, increased contraceptive use can significantly reduce the costs of achieving selected MDGs and contribute to reductions in maternal and child mortality, major goals of the MDGs. Given the importance of these goals, it is crucial for countries to invest in family planning as a successful and cost-effective tool to complement other national socioeconomic development efforts.

A01: 2

**Prerequisites to meet Family Planning Unmet Needs in Sub-Saharan Africa**

Jean-Pierre Francois Guengant¹, John F. May²

¹Institut de Recherche pour le Développement, Burkina Faso; ²The World Bank Africa Region, AfTH2; guengant@ird.bf

(1) Background/Significance;

Efforts to increase the use of family planning in sub-Saharan Africa over the past 30 years have failed. Present levels of modern contraceptive use range between 5 to 30 percent in most countries of Western, Central, and Eastern Africa. Current family planning unmet needs concern 15 to 30 percent of women in union. In most cases unmet needs are higher than current use, and in several countries they even represent two to three times the current use.

(2) Hypothesis or Intervention/Activity Tested

Yet this is only part of the story, since in many countries, total demand for family planning (current use plus unmet needs) ranges between 25 to less than 50 per cent of women in union, against 70 to 80 per cent in most other developing and least developed countries. This is the result of a double denial of African
women reproductive rights. The first denial is lack of access for those women who express a need in family planning and are not using any method. The second denial is the lack of expressed desires by so many women, a reflection of the low level of women’s empowerment and information on reproductive matters in traditional societies. Therefore there is ample room for increasing contraceptive use in in sub-Saharan African countries

(3) Methodology, (4) Data
Using the data of national surveys on fertility and contraceptive use undertaken in most sub-Saharan countries over the past 30 years, the authors document these poor results, but more importantly reveal the very slow growth of contraceptive use in recent years.

(5) Findings
For most countries of Western and Central Africa with two or more surveys, increases in contraceptive prevalence have rarely exceeded 0.5 percentage point per year (0.3 percentage point per year in Nigeria between 2003 and 2008, and during the same period a decrease has been observed in Ghana). By contrast, contraceptive prevalence increased by more than 1 percentage point per year in most countries of Eastern Africa, and by more than 1.5 percentage point in several of the least developed countries of South Asia.

Persistent slow growth of contraceptive use in most sub-Saharan African countries makes the Cairo ICPD’s objective of satisfying family planning needs of their population by year 2015 impossible to reach. With an increase of contraceptive prevalence of 0.5 percentage point per year, most countries will not satisfy present unmet needs before year 2050, against 2020 or 2030 with an increase of 1.5 percentage point.

All actors involved in family planning and reproductive health in Africa in the past 30 years are to be blamed for the present poor performance. In the 1980’s and 1990’s, many African governments adopted badly designed population policies which had limited impact. Till now many governments continue to give more attention to maternal and child health and neglect family planning activities. Donors’ priorities shifted to new subjects: prevention of HIV-Aids, environment, governance, climate changes, and this year to the impact of the world financial crisis. Local and international NGOs in Africa followed international changing agendas and paid less attention to family planning needs and rights, since most developing countries had or were about to complete their contraceptive and women right’s revolution, therefore leaving African women behind.

(6) Knowledge Contribution or Lessons Learned.
In this context, the authors propose new strategies both at the international and national levels involving all actors. First, failure of past efforts must be appropriately documented and fully acknowledged. Second, the need to accelerate the pace of growth of contraceptive use in sub-Saharan Africa must be recognized with two complementary rationales: reproductive health rights and social and economic development. Third, an international initiative must be taken to increase the use of modern contraceptive methods in Western, Central, and Eastern Africa to 1.5 percentage point per year over a period of 10-15 years, so that present family planning unmet needs can be satisfied in a reasonable period time. Numbers of women concerned and costs involved should be carefully evaluated, so that both governments and the donors engage together to reach this objective. This can be launched within the framework of the ICPD Plan of Action, but with a better balanced prioritization and funding to each of the main components of Reproductive Health. At the national level, a much stronger commitment from the sub-Saharan African leadership and from the civil society is required. Sustainable funding is also needed, as well as a culture of accountability and a strong Monitoring and Evaluation system. Old population policies must be abandoned and replaced by shorter policy document focussing on population and reproductive health issues with quantitative goals on contraceptive prevalence increase. All Sectors’ policies (in Health, Reproductive Health, and Reproductive Health Commodities, etc.) should adopt the same objective and targets. It is recommended to achieve this within the framework of the PSRP of each country.

AO1: 3
Contraceptive use in urban sub-Saharan Africa: Recent trends and differentials set in the policy and program context
Jean Christophe Fotso1, Ilene Speizer2, David Guilkey2, Gwen Morgan1
1African Population and Health Research Center (APHRC), Kenya; 2University of North Carolina at Chapel Hill (UNC), USA: jcfotso@aphrc.org

Background
Many sub-Saharan African countries experienced dramatic drops in fertility from rates as high as 8 children per woman in the mid 1970s to around five by the mid 1990s. At the same time, the contraceptive prevalence rate (CPR) increased rapidly as women began wanting fewer children. These positive trends however came to a halt in the late 1990s (Westoff & Cross, 2006; Curtis & Neitzel, 1996). The unmet need for contraception remains high in the region as family planning funding continues to become scarce and existing programs fail to meet the concerns and desires of their users (Prata et al., 2008; Casterline & Sinding, 2000). Low contraceptive use and high unmet need have resulted in an increase in unintended pregnancies, which pose health risks and contribute to infant and maternal ill-health and death (Adetunji, 1998; Gipson et al., 2008). Overall, high population growth coupled with high levels of unintended births will undoubtedly hinder progress toward the Millennium Development Goals (Potts & Fotso, 2007; Cleland et al., 2006; White & Speizer, 2007). Importantly, there are significant inequities in reproductive health outcomes, with the poor tending to have not only the lowest CPR, but the highest total fertility rate and the highest unmet need for family planning (Gillespie et al., 2007; PRB & APHRC. 2008). Few studies have documented trends in CPR and their differentials by socioeconomic status with a focus on urban areas, which are projected to be home to more than half of the region’s population in the next decade.

Research
This paper seeks to 1) describe trends in contraception use in urban areas of three sub-Saharan African countries; 2) examine how these trends vary between the urban poor and the urban non-poor; and 3) investigate the extent to which these findings may be explained by family planning (FP) and reproductive health (RH) policies and programs in the target countries.

Data and Methodology
The study is based on data from the demographic and health surveys (DHS) in three sub-Saharan African countries where a major five-year urban reproductive health program will be implemented with funding from the Bill & Melinda Gates Foundation. Samples of women aged 15-49 are retrieved from the following DHS datasets: Kenya (1993, 1998, 2003); Nigeria (1990, 1999, 2003); and Senegal (1992/93, 1997, 2005). The outcome variable is the current use of modern contraception. The key predictor is the survey period defined as period 1 (1990-93), period 2 (1997-99) and period 3 (2003-05). Other predictors of interest are household wealth recalculated based on all urban households, and education. The control variables include working status, age, parity, type of union and religion. To account for the possible correlation of the outcome among women from the same sampling clusters, the study uses multi-level models. Two-level logistic regressions are carried out for the pooled data and for each country using the appropriate statistical methods. The analyses are restricted to urban, currently married, not pregnant and not sterilized women. We augment the DHS data with data from a review of FP and RH policies and major programs implemented in the target countries during the period covered by the study (1990-2005).
Preliminary Findings

Our descriptive results show a pattern of increase in modern contraceptive use between period 1 and period 2, and seemingly downward trends thereafter. The bivariate analyses indeed confirm a statistically significant increase in urban CPR between period 1 and period 2 in Nigeria, Senegal and in the three countries as a whole (p<0.001). In Kenya, the change, though positive did not reach statistical significance at the level of 0.10. There was no significant change between period 2 and period 3, tough downward trends appear in Nigeria, Senegal and the three countries as a whole.

Further, there are huge CPR gaps between the urban poor and the urban non-poor (both in terms of wealth and education). The interactions between survey period and wealth reveal no differences in the CPR trends by wealth, except that in Senegal and subsequently in the three countries as a whole, CPR declined among the rich and increased among the poor between periods 2 and 3. The interactions between survey time and education show that in the three countries as a whole and among secondary educated women, the increase in CPR between periods 1 and 2 was shallower while the decline between periods 2 and 3 was steeper, compared to trends observed among women with no education.

These findings which were confirmed to a large extent in the multivariate models, will be discussed against the major FP and RH policies and programs implemented in the target countries during the period covered by the study.

Knowledge Contribution

To be completed after the policy and FP/RH program review.

References


A01:4

Promoting family planning within the context of environmental management yields higher MDG achievement: Evidence from the Philippines

Joan Regina Lupoyon Castro¹, Leona Ann D'Agnes²

¹PATH Foundation Philippines Inc, Philippines; ²PATH Foundation Philippines Inc, Philippines; jcastro@pfpi.org

Background/Significance: The Philippines is a nation of 85 million people and one of the fastest growing countries in Asia. Majority of Filipinos reside in the coastal zone where rates of fertility, teenage pregnancy and unmet need for family planning (FP) exceed national average figures and contribute to high poverty incidence (44%) among fisherfolk. Resistance from religious leaders and conservative groups undermine efforts to promote FP while geographic barriers pose challenges to contraceptive access and use in rural coastal areas. Other data showing children of fishers are more likely to be underweight – particularly if their mothers do not practice family planning - suggest interrelationships between poverty, high fertility and malnutrition in fishing communities. Integrated approaches to population and environmental management present opportunities to promote FP within the broader context of poverty alleviation while responding holistically to the multifaceted needs of fishing-dependent communities.

Operations Research Hypothesis and Interventions: A quasi-experimental evaluation design was implemented to examine the hypothesis that integrated approaches to population and coastal resource management generate higher impacts on human and ecosystem health outcomes compared to sectoral management approaches. In one experimental site, population/reproductive health (Pop/RH) interventions were implemented in isolation. In a second site, coastal resource management (CRM) interventions were implemented independently. In the third experimental site, Pop/RH and CRM interventions were implemented in an integrated fashion (the "iPOPCORM" intervention).

The Pop/RH intervention aimed to build the capacity of local institutions to deliver family planning (FP) information and counseling for informed choice, community based distribution (CBD) and social marketing of non-clinical methods of contraception (condoms, oral pills), and peer-mediated behavior change communication (BCC) for pregnancy prevention.

The CRM intervention sought to build local capacity to deliver coastal conservation education, establish and manage marine protected areas (MPA), formulate community-based management plans and committees, safeguard the protected areas, implement mangrove reforestation, and encourage compliance with laws prohibiting use of dynamite and cyanide in fishing.

The Integrated Population and Coastal Resource Management (iPOPCORM) intervention focused on building local capacity to deliver the same Pop/RH and CRM interventions in an integrated fashion in order to improve food security from the sea.

All three models include an economic development component that supported environment-friendly enterprise development (EED) training and micro-credit facilities targeted to economically disadvantaged groups in coastal areas, mainly women and youth.

Methodology: The three intervention models were implemented in three distinct areas of Palawan Province by selected NGO partners working in collaboration with local governments and PATH Foundation Philippines. Independent research groups conducted community surveys and ecological assessments in the three study sites before (2001) and six years after (2007) the interventions were introduced. The implementing NGO partners also implemented period behavioral
monitoring surveys (BMS) to track changes in family planning and fishing practices among the target groups which primarily consisted of fishers, women and youth.

Data: Eighteen ecosystem health indicators are included in the analysis, grouped under three categories: coral reef, reef fish, and mangroves. Nine human health/wellbeing indicators were also examined under two categories: reproductive health and food fish security. Regressions analyses were performed on the 2001 and 2007 datasets to examine the statistical significance of the differences in the indicators over time while controlling for other related factors.

Findings: The IPOPCORM intervention generated higher impact on both the Pop/RH and CRM indicators compared to the sectoral management approaches. Among others, the data show a positive and statistically significant change in use of any FP methods among adults and youth, significant decline in use of dynamite and cyanide in fishing, and fewer young adults reporting income levels below poverty threshold. More positive and statistically significant trends in coral and mangrove condition indices were also observed in the integrated site. BMS data indicate fish catch rates doubled and fishers’ average monthly income increased by 21% in the IPOPCORM site. Community leaders noted that IPOPCORM was able to deflect opposition from religious leaders by promoting family planning as an integral component of CRM for food security.

Knowledge Contribution or Lessons Learned: Integrated approaches to family planning and environmental management generate higher yields than sectoral management approaches and contribute more directly to MDG achievement. The IPOPCORM intervention contribute directly to MDG1 (eradicate extreme poverty and hunger) by reducing poverty incidence among fishers and youth. By enabling women to participate more fully in CRM and livelihood activities, IPOPCORM contributed directly to MDG3 (promote gender equality and empower women). It also generated higher levels of family planning and safer sex practices among adults and youth which contribute directly to MDG 4 (reduce child mortality), MDG 5 (improve maternal health) and MDG 6 (Combat HIV/AIDS). The integrated approach also enhanced the community’s role in CRM while the RH component lends sustainability to CRM gains – both of which contribute to MDG 7 (ensure environmental sustainability). The public-private partnerships fostered under the project contributed to MDG 8 (develop a global partnership for development).

**B01: Measuring and Responding to Unmet Need**

**Time:** Monday, 16 November 2009: 9:30am - 11:00am

**B01: 1**

**When One Size Doesn’t Fit All: Using Client-Centered Market Segmentation Analysis to Tailor Family Planning Interventions in the Philippines**

Wenjuan Wang, Rebecca Patsuka, Ruth Berg, Sara Sulzbach
Abt Associates Inc., United States of America; wenjuan_wang@abtassoc.com

**BACKGROUND**

Recent Demographic and Health Survey (DHS) and National Family Planning Survey Data in the Philippines show that family planning (FP) use has reached a plateau, with a modern contraceptive prevalence rate of 33.4%. However, 17% of married women report unmet need for family planning and nearly 40% of women not currently using a contraceptive method state that they intend to use a FP method in the future (DHS 2003). These findings indicate a significant latent demand for family planning. To translate this demand into method adoption, it is important to implement FP programs that are tailored to specific subgroups, as generalized campaigns fail to address the differing FP attitudes, goals and needs of diverse segments of the population.

The USAID-funded Private Sector Partnerships-One (PSP-One) project developed an analysis tool – Client-Centered Market Segmentation -- to help FP programs tailor their interventions and messages to the needs of specific segments of the population. The objectives of this study include: identifying FP market segments based on multi-dimensional characteristics; profiling each segment in terms of social and demographic characteristics, FP attitudes, values, and other characteristics; and developing strategies that program managers, particularly those involved in behavior change communication, can use to effectively respond to the FP needs of different population segments.

**METHODOLOGY**

Between May and July of 2007, PSP-One implemented a national survey, consisting of structured interviews with women between the ages of 15 and 49. A probability sample of 4,000 women was selected using a multi-stage sampling method. The survey collected information on women’s FP values, beliefs, attitudes, behaviors and needs, as well as demographic, economic and media habit information.

A variation of the CHAID algorithm was used to identify FP market segments. The process divides the sample into distinct clusters in terms of a series of attitudinal, value and belief variables. The algorithm proceeds through iterative division of the sample into two subgroups; the partition is used to create two homogeneous groups which differ on one key demographic variable. The homogeneity is measured by minimizing the pooled within-group sum of squares (WSS) across all attributes. The process repeats until all clusters are too small for additional sub-divisions.

This analysis focused on non-users, totaling 2,777 women. Sampling weights were calculated and accounted for in the analysis.

**FINDINGS**

The market segmentation analysis identified six segments of non-users of contraceptives, named to reflect key characteristics of each group:

- **Segment 1:** Young Rural Intenders (14% of non-users),
- **Segment 2:** Young Urban Intenders (35%),
- **Segment 3:** Low-Income Traditionalists (13%),
- **Segment 4:** Conventional Skeptics (12%),
- **Segment 5:** Ready-to-Limit Conservatives (18%), and
- **Segment 6:** Ready-to-Limit Pragmatists (8%)

We profiled each segment on the basis of general health attitudes, fertility desire, FP awareness, attitudes, beliefs, and media habits. For example, in general, Young Rural Intenders are not sexually active, and believe that both partners in any type of relationship should be involved in contraceptive decision-making. They are more likely to believe that the number of children should be left up to God. However, they doctors and family members are trusted sources for information about contraception. Ready to Limit Pragmatists exhibit positive attitudes toward FP and intend to use contraception in the future. Their attitudes have a distinctly feminist perspective; they are more likely to believe that a woman should pursue a career before having children and that contraception in a marriage is the wife’s decision.
To target specific market segments with behavior change communication, we used the Process of Behavior Change (PBC) framework and mapped segments to different stages of behavior change based on their profiles. Segments 1 and 2 were classified as being in the preknowledge stage; segments 3 and 4 were in the knowledge stage; and segments 5 and 6 were in approval/intention stage. To maximize the effectiveness of limited resources, it is necessary to prioritize FP resources towards certain segments. The findings suggest that segments 5 and 6 should be a priority, as they these groups are most likely to adopt a FP method according to the PBC framework and they demonstrate few cultural barriers to use. Recommendations for behavior change communications efforts are specified for each group, including the types of messages and delivery methods.

PROGRAM IMPLICATIONS/KNOWLEDGE CONTRIBUTION

Client-Centered Market segmentation allows a broader, multi-dimensional segmentation of the FP market by highlighting group differences in values, beliefs, and attitudes— key drivers of FP demand and use. The analysis and synthesis of these findings provide key inputs for designing tailored communications approaches to translate latent demand into adoption of FP methods. It is anticipated that the results of this study will provide useful information to stakeholders in the public and private sectors to improve the targeting of FP interventions to different population groups in the Philippines.

801: 2

Understanding unmet need: Changes in measurement over time in the Demographic and Health Surveys

Sarah E.K. Bradley, Joy Fishel, Trevor Croft

ICF Macro, United States of America; sarah.e.brady@macrointernational.com

(1) Background/Significance

Unmet need, or the percentage of women who are not currently using a method of family planning and want to stop or delay childbearing, is a measure that is widely used for advocacy, the development of family planning policies, and the implementation and monitoring of programs worldwide. Yet, the calculation of unmet need remains complex and is not widely understood. Furthermore, the definition and calculation of unmet need has changed over time, and has been applied in different ways to different rounds of Demographic and Health Survey (DHS) data, making comparisons across time difficult and potentially misleading.

As unmet need has been adopted as a Millennium Development Goal (MDG) indicator, understanding this indicator and its comparability over time has become crucial. In this paper, we 1) outline how the DHS calculates unmet need, both currently and in previous DHS rounds (1,2) apply the current (DHS V) definition of unmet need to earlier surveys that used different definitions of unmet need to make estimates comparable across time, and 3) discuss the newest definition of unmet need that does not require the inclusion of contraceptive failure, which will provide the opportunity for a consistent definition to be used across countries and time points in DHS surveys moving forward.

(2) Hypothesis Tested

We hypothesize that in all but a few cases applying the current definition of unmet need to previous surveys will only slightly change older estimates of unmet need that were calculated in previous rounds. Countries in which large differences in levels of unmet need are found when comparing older and newer definitions of unmet need will be highlighted, and reasons for these differences explored.

We further hypothesize that with a stronger understanding of exactly how unmet need is calculated, together with a consistent definition of unmet need moving forward in the DHS, the indicator will be more easily interpreted by a wider audience, and better used as an MDG indicator.

(3) Methodology

We will first show graphically how unmet need is calculated, and how the calculations have changed over the years. Specific examples from countries with multiple surveys, including Uganda, will be used to demonstrate the impact of changes in definitions.

Second, we will retrospectively apply the current definition of unmet need to data collected in previous DHS rounds whenever data allow. Third, in countries that use a more complex definition of unmet need that includes contraceptive failure collected from the contraceptive calendar, we will re-calculate unmet need without including failure in the calculation. When applicable, confidence intervals will be produced so estimates of unmet need can be compared to see whether the difference between the old and new estimate is statistically significantly different.

(4) Data

All countries which had at least 2 DHS surveys that collected all necessary data for the calculation of unmet need (that used the core questionnaire from DHS rounds II-V) will be included in analysis. This includes approximately 122 surveys in 45 countries. Additional surveys that become available prior to completion of this analysis may also be included.

(5) Findings

Based on preliminary analyses, applying the current definition of unmet need retrospectively changes levels of unmet need only marginally. For example, applying the current definition of unmet need to Uganda changed the total estimate of unmet need among married women in 2000 from 34.6 to 34.7 percent, and in 1995 changed the estimate of total unmet need from 29.0 to 29.7 percent. Changes in unmet need for spacing and limiting were similarly small. Thus far, changes in levels of unmet need due to differences in definitions do not appear large enough to change any policy or programmatic recommendations. However, further research is needed to determine whether differences in unmet need due to changes in definitions are consistently negligible across countries and time points. The research proposed here will fill that need.

(6) Knowledge Contribution

As use of the ‘unmet need’ indicator increases, so does the need for better understanding of exactly how unmet need is calculated and whether estimates of unmet need produced by the DHS are comparable across time points. This paper will outline how the DHS calculates unmet need, both currently and in previous DHS rounds; provide an evidence base from which users can decide whether results are comparable over time; and discuss how the DHS will estimate unmet need moving forward. This research will go a long way in ensuring the quality and comparability of one of the most important MDG indicators and will inform advocacy efforts for family planning and maternal and child health policies and programs across the globe.


801: 3

Building a balanced method mix: The potential sustainability of low-cost implants in family planning programs
1. Background/Significance

As a highly effective and long acting means of avoiding unintended pregnancy, contraceptive implants have an important role to play in the family planning method mix. However demographic and health surveys from several African countries indicate low uptake of implants, particularly when compared with short term methods such as combined oral contraceptives (COC) and injectables. Low uptake may be the result of frequent stock outs and cost barriers faced by facilities. On-going registrations of a low cost implant across Africa have the potential to address these financial barriers and would contribute to a more balanced and cost effective method mix. Moreover, expanded contraceptive choice is a critical component for women seeking fulfillment of their reproductive health goals. A 2008 analysis revealed that if 20% of COC users switched to implants in Africa, over the next 5 years it would be possible to avert 1.8 million unwanted pregnancies, 576,000 abortions, and 10,000 maternal deaths.

2. Research: State main question/hypothesis

1. What is the actual amount contraceptive implant users in Kenya are currently paying for insertion and removal in the different types of sectors (public; private for profit; private not for profit)?

2. What potential barriers to introduction of lower cost implants exist in Kenya and will fees for service allow for appropriate access to removal?

3. Methodology (including location, setting, period, analysis approach)

This project consisted of two discrete activities: 1) a mail/phone survey with 112 private sector providers in preparation for writing a protocol; and 2) interviews with current and returning implant clients. The data from this presentation are based on the mail survey and interviews with implant clients. Implant clients were interviewed after at least six months of product use. A total of 293 implant clients from 22 different facilities were included in the survey sample.

4. Data (if relevant)

A mail/telephone survey was conducted with 112 private sector providers in August 2006 with a response rate of 58%. In 2007 the retrospective cohort of implant users to be interviewed was identified and the study protocol was approved by PHSC and by the local IRB. The first participant was enrolled in October 2007. Data collection was completed in December 2007. Data entry was completed in February 2008 and data analysis began the same month.

5. Findings

Results of the mail/telephone provider interviews indicate that the majority of recently trained private sector providers (79%) currently provide implants and that their corresponding facilities charge US$2.80—28.00 per insertion with about a quarter (27%) charging US$7 and 15% charging US$14. The interviews with current implant users indicate that clients are paying, on average, $8 (range $0.25 - $50) for implant insertion and 97% were successful in getting their implant removed upon request at a median cost of $3.75 (range $0.25 -$25). Average household monthly income was $350 and survey participants reported being willing to pay a maximum insertion price of $13.75, on average.

6. Research: State knowledge contribution

Provision of low-cost implants has the potential to increase sustainable access to a highly effective contraceptive method. These findings indicate a willingness and ability to pay for insertion of low-cost implants as well as implant removal.

**BO1: 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.

Sikolia Z Wanyonyi1, Evan Sequeira1, Yeri Kombe2

1Aga Khan University Hospital, Kenya; 2CPHC; Kenya Medical Research Institute, Kenya; sikoliaw@gmail.com

**Background**

Contraceptive use is often a lifestyle choice that could impact on the quality of life. There have been numerous quality of life surveys conducted in many disciplines, however, this has been lacking in contraceptive research. Furthermore, despite the cultural diversity in Africa, quality of life tools have not been adequately tested and used locally. Understanding the reliability and validity of existing medical outcome survey tools in the local setting and their applicability in contraceptive research could enable identification of the quality of life impact of different contraceptive methods and thus assist in counselling which may lead eventually to correct choice and hence minimise discontinuation rates.

**Objectives**

To determine the internal consistency and reliability of Short Form (SF)-36 health survey questionnaires among contraceptive users.

**Methodology**

Research question: Is the SF-36 a reliable tool in assessing the effects of contraceptives on the health related quality of life?

Main outcome measures: The eight scales within the SF 36 health profile (physical functioning, social functioning, role limitation attributed to physical problems, role functioning attributed to emotional problems, energy and fatigue, pain, mental health and general health).

Setting: The Aga Khan University Hospital and the Family Health Options family planning clinics in Nairobi, Kenya.

Study period: December 2008 to April 2009.

**Intervention**

A clinical trial was undertaken among 121 clients who opted to use DMPA for contraception. Every consecutive client choosing to use DMPA for contraception was selected to participate in the study. After obtaining an informed consent the clients were recruited upon completion of an anglicised SF-36 questionnaire. Demographic data was also obtained. Only those meeting the eligibility criteria were scheduled for a six month follow-up to determine the quality of life changes.

**Data analysis**

An analysis of the data collection tools was undertaken using SPSS version 15.0. Kline’s criterion of 0.4 was used to test for inter scale correlations while the internal consistency was measured by the Cronbach’s alpha using the Nunnally’s criterion of 0.7. Sub analysis of different variables was undertaken to take into account any confounders.
Findings
The SF-36 questionnaire was administered to 131 consenting clients. An overall response rate of 94.7% was achieved. Of these 106 participants were eligible for the six month follow-up after satisfying the eligibility criteria. The mean age of the respondents was 31.4 years (SD 5.8) with an average family size of 1.7 children. The average desired family size was 2.7 children. Eight percent (8%) of the respondents were nulliparous with no immediate plans for childbearing.

Most of the participants were married (90.8%) and had attained tertiary level of education (78.7%). Approximately 53% of the clients were contraceptives naive prior to choosing DMPA. The mean scores for the eight scale SF-36 questionnaire before initiation of DMPA were: physical functioning 81.4 (SD 22.4), social functioning 77.3 (SD 19.4), role limitation attributed to physical problem 81.6 (SD 31.6), role functioning attributed to emotional problems 76.3 (SD 35.3), energy and fatigue 66.9 (SD 16.4), mental health 71.4 (SD 17.5), general health 74.1 (SD 14.5) and pain 79.7 (SD 22.1).

The SF-36 questionnaire satisfied rigorous psychometric criteria for reliability and internal consistency for 5 of the 8 scales. The Cronbach’s alpha for these scales were: physical functioning (0.89), social functioning (0.56), role limitation attributed to physical problem (0.83), role functioning attributed to emotional problems (0.79), energy and fatigue (0.62), mental health (0.75), general health (0.59) and pain (0.73). The relationship with the spouse and sexual health were tested separately with alpha values of 0.78 and 0.87 respectively. The item scale correlation persistently exceeded 0.4 for all variables. On subgroup analysis there was no significant variation of these values even after adjusting for different age, occupation, family size and level of education.

Lessons learned
These results provide support for the use of SF-36 and other medical outcome survey tools as potential measures of outcome among contraceptives users. These tools are acceptable, internally consistent and a reliable measure of health status among contraceptive users. Knowledge on impact of quality of life among contraceptive users will enable adequate counselling and reassurance in case of side effects and this could minimise discontinuation. However, these results are not generalisable as our population was mainly urban with a high level of education.

This tool should also be tested in the rural and low socio-economic population and if found reliable they should be adopted for use by family planning providers and researchers.

BO1: 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
Getu Degu Alene1, Alemayehu Worku2
1University of Gondar, Ethiopia; 2Addis Ababa University, Ethiopia; adgetu123@yahoo.com

Background: Evidence shows that nearly two million people are added to the population of Ethiopia each year. It has become clear that uncontrolled fertility has adversely influenced the socio-economic, demographic and environmental situations of the country.

Objectives: To estimate the total fertility rates and look into the relative contribution of the intermediate determinant variables in bringing fertility below its biological maximum in North and South Gondar zones of Northwest Ethiopia.

Methods: A cross-sectional study which included a sample size of 3512 women of reproductive age was performed. Multi-stage cluster sampling was used to select the required study subjects. The Bongaarts model was employed to estimate fertility rates and quantify the contribution of each of the proximate determinants of fertility.

Results: The overall total fertility rate of the two Gondar zones was computed as 5.3. Among the three major proximate determinants in reducing fertility in the two zones, postpartum infecundability (C=0.55) stood first followed by contraceptive use (C=0.75) and non-marriage (Cm=0.83).

Conclusion: The fertility-inhibiting effect of postpartum infecundability resulting from prolonged breastfeeding is by far the most important proximate determinant in the entire study areas. A substantial role (particularly in urban areas) is played by contraceptive use. The promotion of breastfeeding should continue by all concerned bodies and the region should continue exerting its maximum effort to make the majority of the rural population users of modern contraceptive methods.

C01: FP for Vulnerable Populations

Time: Monday, 16 November 2009: 9:30am - 11:00am

C01: 1
Innovative effective approaches for increasing family planning access in difficult to access settings
Molly Louise Fitzgerald1, Othello James2, Clarence Massaquoi3, Daniel Dalton1, Florence Davis5
1JSI Research&Training Astarte Project; United States of America; 2Children Smile Humanitarian Network, Liberia; 3PMU-Libera; 4Paracom-Libera; 5Merci-Libera; mfitzgerald@jsi.com

Background/Significance
Recognizing and enhancing the capacity of local organizations represents a crucial step in ensuring sustainable and quality family planning services for vulnerable populations.

Activity Tested
With effective support, the Astarte model hypothesized that local NGOs can scale-up their services and increase geographic coverage. In less accessible communities, local NGOs fill life-saving reproductive health gaps. This is highly relevant in conflict and post conflict settings, where local NGOs are often the only organizations on the ground because of poor security or accessibility.

Methods
The JSI Astarte project works with local health NGOs in the design and delivery of services to address critical gaps in family planning programming. The Astarte project has worked globally for more than 12 years in a range of settings (conflict, post conflict, rural, urban, etc). Local partners are provided small grants to address family planning gaps. At regular intervals, Astarte provides capacity building for enhanced family planning service delivery plus organizational strengthening to improve sustainability of the programs. The effectiveness of the Astarte approach is demonstrated by the sustained success of past partners. In Pakistan, a partner first providing services to Afghan refugees in the 1990’s, is now one of the lead reproductive health agencies in the current Pakistan crisis.
In Sierra Leone, a midwife organization provided services to fellow refugees and nationals in Guinea. Since repatriating to Sierra Leone after the war the group has continued to provide life-saving family planning and other Reproductive health (RH) services in Sierra Leone.

Findings

NGO programs with current Astarte grants for services in Liberia have demonstrated a number of achievements in this first year of the multi-year initiative. Initial outcomes for these organizations show that relatively modest investments in the form of small grants and capacity building enhances the effectiveness of local organizations by making them more sustainable; better connected; and better able to provide more comprehensive better quality family planning delivery as a result of the grants and capacity building work.

Lessons Learned

As demonstrated in other Astarte sites, 1) The Liberia initiative has increased organizational sustainability by offering the four local NGOs the opportunity to leverage additional funding from other donors by granting a $10,000 seed grant to build an organizational base and track-record. UNFPA has supported the initiative through supplemental grants. 2) The project facilitated in-country and external linkages. The Ministry of Health and Social Welfare has collaborated with the NGOs on the county level, and the NGOs are supporting priorities identified by the MOHSW. The programs have linked with each other within Liberia and outside Liberia sharing lessons learned at national workshops and an international reproductive health in emergencies conference. 3) At the end of the year, all four NGOs had expanded the number of areas of RH covered, and program managers and staff demonstrated increased knowledge and skills required to deliver quality RH programs. For example, one program addressed adolescents by integrating youth activities into its current community based violence and HIV prevention activities.

C01: 2

Targeting public sector resources and efforts to improve access to FP services among the Poor in Peru

Suneeta Sharma, Gracia Subiria

Futures Group International, United States of America; ssharma@futuresgroup.com

Background/Significance: Peru faces a high level of poverty and large-scale inequalities in health outcomes ad access to services between urban and rural populations and between indigenous and non-indigenous populations. Despite these challenges, the government is committed and motivated to address poverty and inequality, seeing it as integral to the development of Peru as a nation. The government, across multiple ministries and other public agencies, continues to fine tune its strategies to better reach the poor with a broad range of health and social services. Additionally, Peru continues to undergo health sector reform, a process that presents many opportunities to ensure more efficient and effective health services delivery, particularly to rural and remote areas where the majority of the poor reside.

Program - State intervention/activity tested: In efforts to address low levels of family planning use and to respond to the family planning and reproductive health (FP/RH) needs of poor women, we devised a two step process. First, we aimed to identify and understand barriers that affect poor women’s access to and use of family planning services. Secondly, we integrated our interventions to address identified barriers into existing financing mechanisms in order to ensure a sustainable and replicable response.

Methodology (including location, setting, period, analysis approach): We selected Junin region as the region has two main indigenous groups that reside in the Sierra and Jungle areas and are traditionally underserved by social programs. More than 7 in 10 people in Junin live in poverty (53%) or extreme poverty (19%).

We conducted a secondary analysis of DHS 2004–2005 data to obtain a profile of poor women and their FP behaviors and carried out a political mapping and systems analysis, which included mapping regional stakeholders, identifying other social programs and efforts to reach the poor, and documenting planning and resource allocation processes at the decentralized level. We then conducted key informant interviews and focus group discussions with regional health authorities, healthcare providers, and poor women and men.

Findings: The analysis and interviews revealed a long list of barriers to seeking, receiving, and providing FP methods and services. Of these, some of the main barriers were (1) lack of accurate, culturally appropriate information about modern FP methods; (2) limited financing for training, supervision, monitoring, and information, education, and communication (IEC) for family planning; and (3) operational barriers resulting from the integrated health model and its effects on FP product and service provision. In close collaboration with the national and regional stakeholders, we selected three strategies for implementation: (1) strengthen and operationalize the FP/RH educational component of the JUNTOS conditional cash transfer program; (2) mobilize regional resources for IEC campaigns and quality improvement; and (3) advocate for inclusion of family planning in Peru’s social insurance program. These strategies use a mixture of strategic (amending health policies at the national level), tactical (addressing the administrative challenge of translating policies into programs at the regional level), and operational (addressing local-level service delivery and implementation) approaches to overcome barriers to access for poor and indigenous women.

This activity has been very successful and achieved high level results including (1) Operationalization of the RH ‘charlas’ (chats) component of the conditional cash transfer program has been successful in removing barriers to access caused by lack of culturally appropriate information and resulted in increased attendance at sessions (from 568 to 1,000 women in six months). (2) In December 2008, the Office of Planning and Investment approved a proposal for approximately US$1.8 million for FP/RH over 10 years. (3) On March 17, 2007, as a result of the project’s sustained engagement, the President of Peru and Minister of Health published Supreme Decree N°004-2007-SA, which establishes a “prioritized list of obligatory health interventions that must be conducted in [health] establishments that receive financing from SIS.” The decree lists reproductive health (counseling and family planning as established in MOH norms) as one of eight preventive priorities, with 100 percent coverage.

Program- State lessons learned: We will share lessons learned, recommendations for scaling up, and potential for replicability of the selected approaches. The lessons include: [1] policymakers and planners must think through both the short- and long-term consequences of alternative policies prior to implementation. (2) use evidence-based country-driven process for designing and implementing strategies (3) use of multiple strategies and financing interventions helps to reach different segments of the poor population and ensure sustainability in the long run. (4) policies should be designed not only for the poor, but with the poor to ensure that programs properly address their needs, (5) integrating FP/RH components into existing financing and social assistance mechanisms for the poor sets the stage for potential scale up and fosters sustainability. (6) regular monitoring using equity-based indicators is needed to ensure that programs are on track and are reaching intended beneficiaries.

C01: 3

Family Planning as a Basic Life-Saving Skill: Lessons from Africare’s Program in Rural Liberia

Rachel Louise Criswell, Marietta Yekee, Claudette Bailey

Africare-Liberia; rachelcriswell@gmail.com

(1) Background
Fourteen years of civil conflict in Liberia left the health system devastated and the health of the population at an incredible low, with a maternal mortality rate of 994 per 100,000 live births (LDHS 2007). Many of these deaths are caused by unmet needs during obstetric emergencies resulting from complications due to inadequate birth spacing, teenage pregnancy, and contraindication to pregnancy. Many of these complicated pregnancies are unintended, and preventable through use of family planning. However, due to a lack of provider skills and cultural mores, the uptake of family planning services in Liberia is low, as shown by a national contraceptive prevalence rate (CPR) of 11% and an unmet need of 36% (LDHS 2007). The majority of women who use contraceptives rely on male and female condoms, contraceptive pills (combined oral contraceptives and progestin-only pills), and injection contraceptives.

In spite of the terrific need for skilled reproductive health and family planning providers, Liberia is undergoing a human resource crisis. There is an acute shortage of certified midwives (CMs), the first line health providers for both maternal and family planning care, with only 325 CMs working in Liberia as compared to the 1634 required (National Health Conference 2008). The production and education of CMs is slowed by the limited number of training institutions. Only four of the eight Liberian health training institutions run certified midwifery programs. The trained CMs who are currently working in health facilities are already overburdened with a large case load, and frequent training programs would take these much-needed personnel out of the clinic, where they are most in demand.

(2) Intervention

In an effort to fill the gap for skilled attendants in all aspects of reproductive health, Africare’s USAID-funded Improved Community Health Project (ICHP) in partnership with the Family Health Division (FHD) of the Ministry of Health and Social Welfare (MOHSW) of Liberia and the American College of Nurse-Midwives (ACNM) developed and implemented the Basic Life-Saving Skills (BLSS) training throughout Liberia. The 10-module BLSS training addresses issues of maternal mortality directly by teaching participants emergency obstetric care, but it also broadens its scope by addressing the root causes of pregnancy complications: inadequate access to family planning. During the BLSS training the practical skill of IUD insertion and removal in order to increase the method mix and increase access to longer-term methods of contraception.

(3) Methodology

A needs assessment was conducted by the ICHP, the FHD of the MOHSW, ACNM, the Bong County Health Team, representatives from Phebe Hospital, the Tubman National Institute of Medical Arts (TNIMA), Liberia Prevention of Maternal Mortality (LPMM) and Cuttington University Nursing Division in February 2006 in order to adapt the standard BLSS curriculum to meet Liberia’s specific needs. Nine CMs were trained from Phebe Hospital in Bong County in August 2006 as master trainers. By the end of 2007, ICHP had trained 105 professional health workers in 9 of the 15 counties in Liberia. Since then, the MOHSW has adopted the training nationally, and BLSS training is currently being rolled out for all service providers nationwide.

IUD insertion was taught from a theoretical perspective in the first set of trainings, and two-week practicals were introduced in 2007 at Phebe Hospital in order to improve provider skill and confidence. Following these practical trainings, further practicals were implemented in the family planning clinics sponsored by the Family Planning Association of Liberia.

(4) Findings

While the BLSS training itself was highly successful, the IUD component met with only limited success. Some providers were able to use their training to increase the number of methods they could offer their clients—in Zebay Clinic in Bong County, one midwife provided IUDs to ten clients after the BLSS training. However, the majority of providers had a low response to the training and did not use it to increase the method mix offered to clients. This was in part due to a lack of confidence in their own insertion skills and in part due to a lack of counseling skills.

(5) Lessons Learned

The experience of the IUD insertion training as a part of the BLSS training component of the ICHP shows the necessity of an integrated approach to increased service delivery. While the BLSS training provided health professionals with the skills to insert IUDs, it did not incorporate a behavior change component to alter the pre-existing provider bias towards contraceptive pills, condoms, and injections. Further examination and comparison with some of the other trainings conducted under the ICHP indicate that a more effective approach involves clearly stating the end objective of the training (in this case, increased method mix) and the problem with the current approach (eg. provider bias limits client choice).

Integration of training, especially in the field of reproductive health, is an efficient means of conveying a lot of information and the linkages between various topics, but without an effective behavior change strategy and complementary counseling training, it is not an effective means of changing provider behavior.

CO1: 4

Reproductive Health Commodity Security in post-conflict situations, a case of northern Uganda

Sarah Mbabazi, Dorothy Balaba

Program for Accessible Health, Communication and Education, Uganda; pace@pace.org.ug

Background

Although the International Conference on Population and Development (ICPD, 1994), highlighted the objective of universal access to reproductive health care by the year 2015, to many developing countries this is a dream given the multiple infrastructural and commodity security limitations.

According to the Ugandan Annual Health Sector Performance Report 2005/06, 73% of health units had a monthly store-room stock-out of one or more HSSIII indicator commodities.

In northern Uganda given the effects of the 20-year insurgency on the health system, structures and services at all levels of the health care continuum especially reproductive services have been affected by poor availability and supply of reproductive health commodities. Recognizing these challenges, in particular, a secure supply of reproductive health products, the Program for Accessible Health, Communication and Education (PACE) in Partnership with the United Nations Population Fund (UNFPA) in April 2008 launched a pilot public-private partnership project to ensure reproductive health commodity security in two districts in northern Uganda that ends in June 2009.

Program

The pilot project is a partnership project that is comprised of a core group of partners at the national, district, health sub district, health facility and community levels each with specific roles. Core partners include Ministry of Health-Reproductive Health Division, National Medical Stores (NMS), UNFPA, PACE, district health teams, Medicine and Therapeutic Committees, health workers and Village Health Teams (VHTS).
The project works to improve the reproductive health commodity security especially contraceptives and condoms at district and lower level health structures. The focus is on capacity building of districts, health sub districts and health workers in logistics management, distribution and demand creation to promote utilization of RH commodities.

Methodology: The intervention which benefits the districts of Pader and Kitgum in Northern Uganda is based on the principle of public ‐ private partnerships for health in which the health sector is committed to making the private sector a major partner in national health development. A number of strategies were used including the development of a reproductive health Commodity security strategy, on ‐ job training of health workers in logistics management, procurement of RH commodities, supporting coordination structures at central and district levels, supporting the distribution of RH commodities from one level to another, and creating demand for RH commodities at community level.

Findings:
To date 80 health workers have been trained in logistics management at the district and health sub district levels. Seventy health facilities have been stocked with contraceptives and 160 Village Health Team members (VHTs) equipped with communication skills and knowledge on family planning in order to promote utilization of contraceptives. Demand creation activities such as radio talk shows by members of the district health teams and health workers have been held as well as production of information, Education and Communication (IEC) materials to further promote utilization of contraceptives. This has resulted in lead times taken for NMS to process and deliver orders at district level being reduced from about 8 weeks to 3-4 weeks. The project has ensured no stock ‐ outs of FP commodities in at least 64 health facilities at all levels of healthcare in both districts

• Lessons learned

Partnerships especially public ‐ private are very important in addressing bottlenecks in the supply chain of RH commodities especially improving the lead times taken for the National Medical Stores to process and deliver commodities at the district level as well as ensuring no stock ‐ outs of FP commodities at health facilities.

• Service providers cannot do their jobs without the reliable operation of public and private sector supply chains delivering the “six rights”: the right product, to the right place, at the right time, in the right quantity, in the right condition. In addition, needed products must be on hand when clients come for them. Therefore capacity building in a number of critical functions is of paramount importance in ensuring clients’ ability to choose, obtain, and use reproductive health products.

• Involving community structures such as VHTs in reproductive health commodity security is very important in promoting utilization of contraceptives but is quite expensive in terms of keeping them interested and motivated to do the work and therefore not sustainable in resource limited settings.

Note: An end of project evaluation will be done by 30th June 2009 which will provide more insight on lessons learn and best practices for program roll out.

D01: Integrating FP and HIV Programs I

Time: Monday, 16 November 2009: 9:30am - 11:00am

D01: 1

Integrating Family Planning (FP) services into HIV Counseling and Testing (HCT) services in DRC

Charly Mampuya1, M. Mpingulu1, J. Kibungu1, E. Engetele1, L. Maluantesa2, J. Kluba3, M.L. Mbo1, M. Mayala1

1Family Health International, Congo, Democratic Republic of the; 2CSR Mvuzi; 3HCR Kenya; 4PNSR; cmampuya@fhi.org

Background

Data from the 2007 Demographic and Health Survey conducted in Democratic Republic of Congo (DRC) show that although 20% of married women don’t want to have more children and 38% don’t want to get pregnant in the next two years, only 5.8% are actually using a modern contraceptive method. These data highlight the huge unmet need for family planning (FP) services in the DRC.

Current investments aiming to expand HIV/AIDS services in the DRC offer an important opportunity to leverage existing efforts to strengthen FP services. With support from USAID, FHI is piloting the integration of FP services into 4 RESA+ VCT services, including integrated and stand ‐ alone sites. The primary partners are those already operational under the RESA+ project: AMO ‐ Congo and Mvuzi reference health center in Matadi; and AMO ‐ Congo and Kenya General Reference Hospital in Lubumbashi.

Objective: To analyze programmatic information from October 2008 to March 2009 on the uptake of family planning in the integration sites.

Methodology

The objectives of the FP/HIV integrated program are addressed through a multi ‐ level intervention that targets decision ‐ makers, health care providers, HIV and FP services clients, community members and other stakeholders. The activities that comprise the intervention are described below:

‑ Conducting a baseline assessment to determine possible models of integration and the needs of HCT and FP programs.
 ‑ Developing and tailoring training inputs, including educational materials, training manuals, and operational procedures.
 ‑ Training providers with a focus on provider ‐ initiated strategies in which providers capitalize on standard HCT conversations covering sexual history, behavior change, risk reduction to screen clients for pregnancy risk, risks of unintended childbearing and necessary referrals.
 ‑ Enhancing the monitoring and evaluation (M&E) system. Indicators of contraceptive method distribution and family planning referral are added to the existing M&E system for HCT. Regular site visits are conducted to monitor the provision of integrated services and provide on ‐ site technical assistance to the site managers and supervisors.
 ‑ Strengthening provision of family planning services through contraceptive commodities supply chain and provision of a diverse method mix.
 ‑ Linking HCT services directly to family planning services, through referrals and creating mechanisms for method re ‐ supply to reduce method discontinuation.
 ‑ Increasing demand for HCT and FP services through community awareness activities.
 ‑ Creating a supportive policy and regulatory environment.

Data

The data were collected by HCT providers at the participating sites as part of their regular health management information system. HCT providers recorded the number of clients who were counseled about FP, the number accepting a method at the HCT service and the number of clients referred to an FP site for either
initiation or continuation of method use. FP providers also reported their service statistics and in addition were asked to determine how many FP clients they saw had been referred from one of the participating VCT sites.

Findings

During the five months that integrated HCT/FP services have been offered 3154 clients were received at CT among which 1238 men (39.25%), 1938 (61.45%) clients were counseled about FP on HCT facilities among which 616 (31.79%) and 1136 clients were counseled about FP on FP facilities among which 238 (20.95%) men.

,The number of clients accessing FP services each month has increased dramatically from 7 to 491 in HGR Kenya and from 16 to 360 at CSR Mvuzi. The most popular methods among HCT clients were condoms (39%), fertility awareness methods (38%), and oral contraceptive pills (17%). Half of the clients (50%) initiating a contraceptive method were aged 18-22.

Note: Almost no clients were seen from October to December 2008 in HGR Kenya due to a nurse’s strike.

Conclusion

HCT/FP integration is a major opportunity to improve FP services access and to reduce unmet needs in DRC. Asking a HCT client about his or her desires for children and current contraceptive use should be a fundamental discussion with any client who engages in heterosexual sex. HCT services, in particular, can serve as an entry point into the formal health care system, not only for those who are infected and uninfected, but also for men and youth, who are two key audiences often missed with traditional or vertical family planning programs.

Integrating FP into HCT programs appears to be an excellent opportunity to reach youth and men about family planning. This is especially important in the case of youth, since the 2007 DHS shows that only 0.5% of women aged 15-24 were using a modern method of contraception.

DO1: 2

Strategies used facilities to integrate Family Planning into HIV Care: What works and what doesn’t

Ibrahim Kirunda1, Nigel Livesley2, Jacinto Amanda2, Zainab Akol3, Kenneth Kasule3

1University Research Co., LLC, Uganda; 2University Research Co., LLC, Uganda; 3Ministry of Health, Uganda; 4Ministry of Health, Uganda; 5 University Research Co., LLC, Uganda; ikirunda@urcchs.com

Authors:

KIRUNDA Ibrahim, University Research Co., LLC, Kampala, Uganda
LIVESLEY Nigel, University Research Co., LLC, Kampala, Uganda
KASULE Kenneth, University Research Co., LLC, Kampala, Uganda
AMANDUA Jacinto, Ministry of Health, Kampala, Uganda
AKOL Zainab, Ministry of Health, Kampala, Uganda
MUHWEZI Augustin, Ministry of Health, Kampala, Uganda

Location of Project: Uganda

Key words: Family-planning, HIV/AIDS and Integration

Conference Theme: - Effective Linkages between or Integration of Family Planning, STV/HIV and Maternal and Newborn Health Programs and Policies

Abstract Text:

Background and Implementation Approach

Family Planning (FP) often gets neglected in HIV care. Yet its importance is because it provides people with protection against unintended pregnancies. To help HIV care clinics improve FP care for their clients the Uganda Ministry of Health and the USAID Health Care Improvement Project (HAPI) implemented the FP-HIV Collaborative with 13 self-selected sites. A collaborative is a quality improvement approach in which site-teams are trained in quality improvement (QI), provided with support from external coaches in applying the principles they learned, and brought together every 3-4 months to share lessons learned about how best to improve care. This sharing is important for providing motivation for change and also for spreading best practices effectively between sites. The goal of this intervention was to offer FP services as an integral component of HIV prevention, care and treatment services for HIV-positive people. A cross-sectional survey was conducted to measure changes over-time in the quality improvement interventions that site teams introduced and were our focus for the study.

Analysis Design and Methods:

Sites collected data from July 2006 until January 2008 on their progress in increasing the number of patients who were counseled on FP. Data were compiled monthly and later verified by external coaches during site coaching. Individual sites started implementing changes to the system of care starting in December 2006 to improve care and these were documented by sites and external coaches. Results were analyzed using the Mann-Whitney test.

Data and Findings:

The percent of adults who were counseled on family planning during clinic visits increased from 59% to 92% (across all sites) after just a few months, and this level of performance has been maintained over the following 12 months. Sites tried a variety of strategies to improve HIV counseling. All 13 provided both additional on-site training in FP to all staff in the HIV clinic and used group counseling to inform patients about the importance of FP. Eight sites used peer counselors to share FP information with other patients. The sites that used this approach increased counseling by 46% compared to an increase of only 10% in those not using peer counselors (p= 0.078). Eleven sites used job aids to remind staff to counsel on family planning. Eleven (11) sites using job aids had an increase of 38% compared to no increase in the two (2) sites that did not use them. Ten sites implemented review records to ensure completeness of data; seven sites dispensed FP commodities in the ART clinic; and two sites conducted family planning training for men. Those sites using these changes showed no higher improvement than those that didn’t.

Knowledge contributions or lessons learned:

Results from the 13 sites show sustained improvement in counseling on FP methods after a quality improvement intervention. Utilization of FP services increased where integration was introduced. Providers found out that integration per say and use of peer counselors reduced stigma among their HIV clients. We also learned that use of job aids is essential in ensuring correct information passed on to clients. We recommend that such an approach be used in other
programs to improve reproductive health care. Further conclusions are limited by the sample size but there is evidence that peer counselors are effective at increasing FP counseling in HIV clinics.

Full contact information
Principal Author
Dr. Ibrahim Kirunda
P.O. BOX 27585, KAMPALA
P.O. BOX 28745, KAMPALA
FAX: +256414288750
OFFICE +256 414 288 751
+256 312 265 920
University Research Co., LLC.
www.hciproject.org
Plot 40, Ntinda II Road, P.O. Box 28745, Kampala

**DO1: 3**

Integration of family planning services into community-based care for people living with HIV in Ethiopia

**Medahnt Wube, Francesca Stuer**
Family Health International, Ethiopia; mwube@fhi.org.et

**Background**
Over the past few years, public health experts have begun to recognize the unmet sexual and reproductive health (SRH) needs, especially family planning, in HIV-positive, home-bound populations. Following the widespread scale up of antiretroviral therapy (ART) for people living with HIV/AIDS, previously bedridden or severely ill men and women are now healthy and resuming sexual activity. Many of these individuals wish to have children, while others want to avoid pregnancy. A study conducted to assess fertility desires and demand for family planning among HIV positive men and women on ART in Addis Ababa, Ethiopia found that among 460 study participants, more than half were sexually active and felt that they needed discussions on fertility issues. Of those participants who were sexually active and not using a contraceptive method during the survey period (214), 39.7% (85) wanted to use family planning in the future.

Since 2007, Family Health International has been working with local NGOs to integrate SRH services, especially family planning, into the existing infrastructure for home- and community-based care (HCBC) for people living with HIV/AIDS in Ethiopia. The integration program is being implemented in 14 HCBC sites across four major regions of Ethiopia – Addis Ababa, Oromia, SNNPR, and Amhara. The program aims to improve SRH in general, and reduce unintended pregnancies in particular, among HCBC clients and their families.

**Program Intervention**
As a first step in the integration process, a consultative workshop was held with government health officials and HCBC implementing partners to discuss the feasibility of integrating SRH activities, including family planning, into HCBC programs. During this workshop, consensus was reached and partners identified possible sites for the intervention. Following the stakeholder workshop, a needs assessment was conducted with HCBC nurse supervisors and program officers at four HCBC programs. They prioritized the following SRH components for the intervention: prevention of unplanned pregnancy and family planning; prevention and management of sexually transmitted infections, including HIV/AIDS; supporting women and children to access maternal and child health services from health facilities, including PMTCT services and infant feeding counseling; and prevention and management of gender-based violence.

Workshops were conducted at 14 sites to sensitize volunteer caregivers and stakeholders representatives from community HCBC committees, health facilities, HIV/AIDS prevention and control offices, and others) on the importance of SRH integration. At the same time, training modules on SRH were developed and incorporated into the HCBC training package. A training of trainers was given to 106 HCBC nurse supervisors, who in turn rolled out the SRH training to 60 social workers and 2127 voluntary caregivers. SRH activities were included in HCBC program planning and implementation. Monitoring and evaluation tools with SRH integration indicators were developed and incorporated into existing recording and reporting formats. In the sites where the Family Guidance Association of Ethiopia (FGAE) is the local NGO partner, commodities were available for distribution at the home level.

**Program Data/Findings**
A total of 21,236 HCBC clients received SRH counseling at 14 HCBC sites between July 2007 and March 2009. Of the counseled clients, 49.3% (10,470) accepted a FP method. Of those clients, the majority 78.5 % (8220) accepted condoms for dual protection, 17.7% (1854) initiated oral contraceptive pills, 6.6% (687) received injectables, and 0.2% (27) received emergency contraceptives. Approximately 13.3 % (2837) were referred to health facilities for other FP services. Of the counseled women, 870 were pregnant and referred for ANC/PMTCT. Of the pregnant women referred for ANC, 47.7 % (415) were HIV positive. Approximately 824 children <5 years were referred for child survival services.

**Lessons Learned**
Field experiences of integrating SRH services with HCBC programs in Ethiopia suggest that HCBC programs are an appropriate and effective entry point for reaching people living with and affected by HIV with important SRH information and services. Healthcare professionals and counselors working at the home and community level can play an important role in increasing access to family planning services and helping HIV-positive individuals understand their reproductive choices. In addition, community members and volunteers, especially people with HIV/AIDS, can be trained and supported to play a vital role in SRH counseling of their peers. Some caregivers were initially reluctant to discuss SRH issues with home and community based clients due to cultural taboos surrounding sexuality. However, timely supportive supervision and refresher trainings helped overcome this challenge. Involving community leaders, family members, and people with and affected by HIV/AIDS, including men, in the planning and implementation of SRH/HCBC integrated services has been integral to the project’s success and will help ensure sustainability of services. However, prior to scale up of the Ethiopian SRH/HCBC model, unified national guidance and support for SRH integration into community-based HIV/AIDS programs is needed.

**DO1: 4**

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

**Meghan Bishop, Beatrice Okundi, Carol Shepherd, Rachel Sanders**

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(1) Background/Significance: HIV prevalence in Kenya is currently 7.8% among adults ages 15-49, and it is higher for women (9.2%) than for men (5.8%). Among HIV-positive women, about half have an unmet need for family planning (FP). Anecdotal evidence shows that people living with HIV prefer to receive all services from one place, and women accessing FP services prefer to receive counseling and testing (CT) from a place they know and trust, such as from their family planning facility. Faced with the dual challenges of meeting unmet need for FP and the HIV pandemic, and given Kenya’s limited resources and medical staff shortages, the Ministry of Health called for the integration of reproductive health (RH) and HIV services. Despite government support, however, integration has progressed slowly.

(2) Activity Tested: The objective of this project was to conduct a policy implementation assessment using a barriers approach to identify achievements related to integration RH and HIV services, as well as any policy and operational barriers to integration.

(3) Methodology: In-depth, semi-structured interviews were conducted from April to June 2007 with 99 key informants (15 policymakers, 33 program managers, and 51 service providers) in four Kenyan provinces where integrated services are offered. The informants were purposively selected based on their involvement in integration activities and in formulating and implementing policies that affect the provision of health services. Three interview guides were prepared for the groups and focused on two main themes: policy issues and operational issues. The interviews were taped and transcribed; data were analyzed using NU*DIST.

(4) Data: N/A

(5) Findings: Respondents reported that integrated services resulted in a number of achievements, including the increased uptake of CT and FP services by clients and reduced HIV-related stigma and discrimination, particularly where CT was offered in FP clinics. Integration of services also increased the acceptance of condoms to prevent HIV, STIs, and unintended pregnancy; increased client satisfaction; and improved the availability of comprehensive and high quality services. Overall, respondents reported that integration saved time and money by reducing duplication of services and empowered clients to make informed choices.

Barriers to integration identified included a lack of a national policy and guidelines, as well as a lack of a specific government framework and budget to support integration. Parallel systems for planning, funding, management, reporting, commodity distribution, and supervision caused confusion. Respondents also reported inadequate capacity, staff, space, contraceptives, and test kits to deliver integrated services. Based on these findings, the Ministry of Health recommended that a national RH/HIV strategy be developed to address and eliminate the identified barriers, identify funding sources, and scale up integration activities.

(6) Knowledge Contribution: The policy implementation assessment showed that integration is feasible and supported in the Kenya public health system. Respondents agreed that integrated services add value to service delivery, promote efficiency, empower clients, and increase services uptake. However, the findings also demonstrate that there are a number of policy and operational barriers to integration—barriers that are frequently found in developing countries. If integration strategies are to be implemented in any country, it is critical that these barriers are addressed and removed. Assessing policy implementation using a barriers approach allows implementers to identify what works and what does not, offering a starting point for scaling up services. This methodology has widespread applicability to sustainable HIV programming.

DO1: 5

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

Jennifer Asuka Leslie1, Emmanuel Munyambanza1, Susan E. Adamchak2, Thomas W. Grey2, Kypomf Kirot2

1Family Health International/Rwanda Country Office; 2Family Health International/North Carolina; 3National AIDS Control Commission of Rwanda; aleslie@doctors.org.uk

(1) Background/Significance: Prevention of unintended pregnancies and adequate birth spacing among HIV-infected women is a cost-effective and essential component of a comprehensive approach to PMTCT. The government of Rwanda (GOR) recognizes family planning (FP) as not only a health intervention but also a priority for economic development. The GOR initiated FP-HIV integration in 2007, including integration of FP into PMTCT services, and is in the process of being rolled-out nationally. By 2010, GOR aims to have integrated FP and HIV services available at 80% of health facilities (HFs) and to reduce the proportion of unintended pregnancies among HIV-positive mothers by 80%.

(2) Main Question/Hypothesis: As a complement to a multi-country assessment of FP-HIV integration, a situation analysis of FP-PMTCT integration was carried out in November 2008, the goal was to provide information to improve integrated services and to optimize the potential for scale-up. The objectives were to determine: the need for FP among PMTCT clients; readiness of antenatal care (ANC) and postnatal care (PNC) providers to offer FP; and to examine FP service provision from the perspective of both the provider and the client.

(3) Methodology: Thirty health facilities with integrated services reported as already being in place, in 15 administrative districts, were selected, representing approximately 30% of the total number of HFs with PMTCT services in the country. HFs with a high flow of ANC clients and a large number of HIV-positive women enrolled in PMTCT were chosen. Within each HF, managers, providers, HIV-positive female clients seeking services, and their male partners were invited for interview. In total, 34 providers/managers, 84 ANC clients, 120 PNC clients and 18 male partners, were interviewed.

(4) Findings: 68% of women in PNC reported using an FP method. Of FP users, 51% said they were using male condoms as their contraceptive method, but use was found to be inconsistent. 20% of PNC clients said they had no current need for FP. Unmet need for FP amongst PNC clients was 12%.

90% of HIV-positive ANC clients expressed a desire not to have children in the future. When these women were asked about the method they would like to use after delivery, 49% expressed a preference for sterilization and 35% indicated they wanted an implant. However, among those women in PNC using FP, only 5% were using long-acting or permanent methods (LAPM). 48% of women in ANC and 69% of women in PNC reported their most recent pregnancy was either mistimed or unwanted.

Most providers (80%) reported that they raise the topic of FP with their clients, and that they refer those that express a need to the FP service. Nevertheless, few clients reported that the provider: discussed with them their desire for children in the future (30% ANC, 15% PNC); referred them for FP services (5% ANC, 12% PNC); or gave them an FP method (7% ANC, 12% PNC).

Analysis of provider attitudes regarding FP and HIV revealed that while providers oppose an HIV-negative woman being sterilized if she has no living children (88%), they were in favor of an HIV-positive woman undergoing tubal ligation (91%).

(5) Knowledge Contribution: Although 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 and results in high unmet need for ‘effective’ FP. Consistent with this, many women in both ANC and PNC reported mistimed or unwanted pregnancies.
Clients express intentions to use FP in the ANC period, particularly LAPM, but few post-partum women reported LAPM use. This implies a latent demand for LAPM among HIV-positive women. Failure to discuss FP issues in the PNC setting is likely a contributor, but communication problems between provider and client could also account for this, given the discrepancy between the number of providers who say they do discuss FP with their clients and client reports that providers seldom raise the issue of FP.

Provider attitudes indicate that they may favor FP not to help HIV-positive women make informed choices about birth spacing and limiting, but simply to encourage them not to have children at all. This attitude seems to reflect a tension between prioritizing prevention of pregnancies and protecting women’s reproductive rights.

It is essential that all women in PMTCT are counseled on their Family Planning intentions in ANC and PNC consultations. Those who would like contraception should receive their desired method. Those who would like to conceive should receive a clinical plan to ensure optimal health of the mother and baby. Better integration of FP counseling and provision into PMCT services will protect HIV-positive women from unwanted pregnancy.

**EO1: Contraceptive Technology I**

**Time:** Monday, 16 November 2009: 9:30am - 11:00am

**EO1: 1**

**Quality Assurance Evaluation of Sino-implant (II): a low cost, safe and effective contraceptive implant**

**David Jenkins, Aida M. Cancel, Markus Steiner**  
Family Health International, United States of America; acancel@fhi.org

**Background/Significance:** Contraceptive implants are a highly effective long-acting method of family planning. Current demand for contraceptive implants exceeds available supply. A barrier to a more widespread use is the high up-front-per-unit cost that prohibits sustainable provision by donors, governments and other agencies.

Sino-implant (II) is a contraceptive implant, that is available at over 60% lower cost than existing implants on the market; and has the potential to break the high cost barrier and be more accessible to programs and to women worldwide. It is manufactured by Shanghai Dahua Pharmaceutical and has been available in China since 1994; it is also registered in Indonesia, Kenya and Sierra Leone. To date over 7 million Sino-implant (II) have been distributed. The product consists of two rods made of medical grade silicone each containing 75 mg levonorgestrel. Eleven published clinical trials, with a total of about 20,000 women followed for up to 7 years show that Sino-implant (II) is safe and effective with an annual pregnancy rate below 1%.

Products manufactured in China face the negative attention brought over a series of highly publicized product safety cases. As part of an extensive due diligence evaluation, we undertook the development and implementation of a quality assurance strategy to ensure that Sino-implant (II) meets international quality standards.

Research: The purpose of this research was to conduct an independent evaluation of Sino-implant (II) to provide assurance of the product quality and verify that it meets international quality standards.

Methodology: A quality evaluation strategy was developed and implemented in 2008. This evaluation strategy included testing of the active ingredient (levonorgestrel), the final product and the packaging material.

Evaluation of the active ingredient was conducted on samples from three lots of levonorgestrel obtained from Yangzhou Pharmaceutical, Shanghahi Dahua's supplier. Test release specifications were conducted according to the US Pharmacopeia (USP) and included tests for identification, melting range, specific rotation, loss on drying, residue on ignition, limit of ethynyl group, chromatographic purity, assay and residual solvents.

The quality evaluation of the final product included: a) tests to verify that Sino-implant (II) met lot release specifications, b) tests to identify potential sources of impurities which could arise from raw materials and/or the manufacturing process, and c) tests to evaluate endotoxin levels and potential tissue reactivity (cytotoxicity).

Lot release verification was conducted on 10 lots of Sino-implant (II). Testing was done by two independent laboratories and used standards approved by the China State Food and Drug Administration (SFDA) that included: identification of the active ingredient, assay, dissolution and sterility.

Potential sources of impurities were assessed in three lots of Sino-implant (II). These include: ethylene oxide residues, trace/inorganic impurities, and residual solvents. Analysis was done on the entire content of the rods, providing an assessment of the overall components found in the implants. Assays for endotoxin, and cytotoxicity were also conducted. These tests were conducted following ISO, USP or ASTM standards.

Package integrity was tested using a bubble emission test. Packaging impurities were tested for buffering capacity, non-volatile residue, residue on ignition and heavy metal content.

Findings: All tests conducted on the levonorgestrel samples met the lot release specifications stated by the manufacturer and were in compliance with the USP monograph requirements.

Lot release testing was verified for 10 lots of Sino-implant (II) and in all instances results were in compliance with the SFDA established product lot release specifications.

Total concentration of ethylene oxide residues were below the established ISO 10993-7 thresholds for each of the residues evaluated.

A total of 15 trace elements were identified in Sino-implant (II) samples evaluated. These trace elements were identified in quantities below 0.01%, except aluminum and zinc that were identified at levels below 0.12%. These quantities were below the USP accepted parenteral daily limits. Inorganic impurities were identified at level of impurities comparable to those identified in Jadelle samples.

Residual solvents likely to be present in Sino-implant (II) are hexane, ethyl acetate and ethanol and these were found at levels well below the USP permitted exposure limits.

Endotoxin levels in all three lots tested were below the endotoxin limit for medical devices and the limits of intrathecally used devices.

No reactivity was evident in the cytotoxicity tests of three lots of Sino-implant (II).

The physicochemical test results of Sino-implant (II) packaging film showed results below the specifications set by the USP. No evidence of package leaks was found in three lots tested.
Knowledge Contribution: Dahuai Pharmaceuticals is capable of producing a contraceptive implant that meets international quality standards. In addition, we now have established a baseline on the Sino-implant (II) product to evaluate the continued quality of the product. A quality evaluation program for Sino-implant (II) has been established and will continue for the next 5 years; including lot release testing of all commercial lots shipped as part of this initiative.

E01: 2
Expanding Contraceptive Options in South Africa: Knowledge, Attitudes, and Practices Surrounding the Intraruterine Device
Sarah A Gutin1, Chelsea Morrioni2, Margaret Moss3, Regina Mlobeli4
1Women’s Health Research Unit, School of Public Health and Family Medicine, University of Cape Town; 2Department of Obstetrics and Gynecology, University of Cape Town; 3Department of Obstetrics, Gynecology and Reproductive Sciences, University of California San Francisco; sagutin@hotmail.com

Background: The intraruterine device (IUD) is a safe, effective, convenient, reliable, and cost-effective form of reversible contraception. It rives female sterilization, injects and implants with respect to effectiveness in pregnancy prevention. Once inserted, IUDs are nearly maintenance free. In many settings however, a number of barriers to usage exist. These barriers often relate to lack of knowledge and misperceptions among both potential users and healthcare providers. The IUD is used widely worldwide but utilization in South Africa is low, despite the fact that it is available free of charge in the public health sector and may be an ideal form of contraception for many South African women.

Activity Tested: This study assesses the knowledge, attitudes, and practices of potential IUD users and health care providers in order to inform strategies for expanding IUD use in South Africa. Understanding what potential clients and providers know about IUDs and their attitudes toward the method would provide important direction in developing interventions to successfully expand use of the IUD in South Africa.

Methodology: We conducted a descriptive, cross-sectional survey among 205 women between 15 to 49 years of age who were attending family planning and STI care services at 4 level public clinics in two South African provinces. In addition, we interviewed 32 providers from 12 clinics (six clinics per province). Ethical approval for this research was obtained from the University of Cape Town and Walter Sisulu University. Permission was also given by the local and provincial health services.

Findings: Among clients, knowledge of the IUD was poor. About 26% of women had heard of the IUD. Ten percent had misconceptions or incorrect information about the IUD that negatively influenced their opinion of the method. After the method was explained to them, 90% of women believed that there were advantages to using the IUD and 75% said they would consider using the method. Women thought the IUD would be an easier contraceptive method to use than oral contraceptives pills (87%), female sterilization (85%), and the injectable (79%).

Provider knowledge about the IUD was inadequate and inadequate. Most providers (84%) knew how the IUD worked to prevent pregnancy but only 19% thought it was very effective at preventing pregnancy. Most providers (63%) believed that the injectable was better than the IUD at preventing pregnancies. Many providers held incorrect beliefs about candidate selection and risks associated with IUD use. When asked to mention categories of women whom the IUD was not appropriate for under any circumstances, 52%, 47%, 28% and 25% thought it was not appropriate for nulliparous women, women with a history of STIs, HIV-positive women and teenagers, respectively. Sixty-six percent of providers believed that the IUD had serious health risks related to it. The most commonly mentioned health risks were increased risk of contracting an STI (59%), ectopic pregnancy (28%), developing PID (22%), and uterine perforation (16%). Almost all (94%) providers said that they needed more training and information about the IUD. Providers reported that barriers to IUD usage in South Africa were a lack of knowledge about the method on the part of providers (84%), a lack of trained providers to insert or remove the IUD (63%), limited availability of the device at health facilities (56%), and a lack of knowledge on the part of potential users (47%). Despite these barriers, 81% of providers believed women would be interested in the IUD if they knew about it and 73% believed the IUD should be promoted in South Africa.

Lessons Learned: This is the first study of knowledge, attitudes and practices among potential users and healthcare providers with respect to the IUD in South Africa. Our results suggest that the IUD would be a welcome addition to the contraceptive method mix in South Africa. Among potential users in this study, the IUD was relatively unknown and knowledge about the method was poor. Women generally had positive attitudes toward the IUD once they learned more about it. In South Africa, public education programs about the method would be necessary for building public support and interest in the IUD. Women cited many adverse reactions to IUD use. Education campaigns could focus on these key advantages with only minimal attention given to dispelling the myths that were not especially prevalent among those surveyed.

The healthcare providers in our study displayed inadequate knowledge about the IUD including erroneous information about the method’s effectiveness and safety and unnecessarily restrictive views about candidate selection. It will also be necessary to train and educate providers, focusing on up to date information, dispelling myths, and proper insertion and removal techniques. South Africa could expand IUD availability and increase women’s choice by adding this valuable, viable, and sustainable option to the contraceptive method mix.

E01: 3
Feasibility of over-the-counter provision of the SILCS diaphragm: experience of women inserting and positioning the device after reading written instructions only in the pivotal trial
Jill I Schwartz1, Maggie Kilbourne-Brook2, Ron G Frezieres3, Mitchell D Creinin4, David Archer5, Lynn Bradley6, Kurt Barnhart7, Alfred Poindexter7, Christine Mauck2, Debra Weiner8, Marianne M Callahan9
1CONRAD/Eastern Virginia Medical School, United States of America; 2PATH, United States; 3California Family Health Council, United States; 4University of Pittsburgh, United States; 5Johns Hopkins Medical Service Corporation, United States; 6University of Pennsylvania, United States; 7Advances in Health, United States; 8Family Health International, United States; jschwartz@conrad.org

(1) Background/Significance: Female initiated and easily accessible contraceptive methods that can protect against pregnancy and sexually transmitted infections are urgently needed. The SILCS diaphragm, a one size, simple-to-use female barrier has been developed by the Program for Appropriate Technology in Health (PATH) after an innovative user-centered evaluation of over 200 prototype designs. Women’s input was utilized throughout the design process, resulting in a single-size diaphragm that is simple to fit and use, comfortable and attractive—all characteristics that may improve acceptability. The SILCS device could be provided over-the-counter where regulatory authority and clinical practice allow and offers discreet, intermittent, non-hormonal barrier protection that could be appropriate for women in many countries. A contraceptive effectiveness and safety study of the single-size SILCS diaphragm in 450 couples began in 2008 and is near completion at six US sites. In this study, each participant agreed to use the SILCS diaphragm with contraceptive gel as her only method of contraception for approximately 6 months.

(2) Hypothesis or Intervention/Activity Tested: In order to assess the feasibility of providing the SILCS over-the-counter, female participants were asked to insert, position and remove the device after reading the SILCS instructions at the enrollment visit. We are reporting on only this aspect of the trial.

(3) Methodology: After enrollment, each participant was given a SILCS diaphragm, contraceptive gel and written instructions for use. The instructions were developed by PATH and pre-evaluated in multiple countries. In order to simulate a situation in which the SILCS user purchased the device at a pharmacy-like location, participants were asked to read the instructions and demonstrate how to insert, remove, and position the device. Participants were then asked to complete the SILCS instructions after reading the instructions only. The participants were then asked to complete the SILCS instructions after reading the instructions only. The participants were then asked to complete the SILCS instructions after reading the instructions only.
setting and would be inserting the device on her own, each participant was given written instructions without verbal or other additional guidance. The participant was given up to 15 minutes to insert the SILCS with the study gel, until she believed that the device was correctly positioned, the device was incorrectly positioned, or she was unable to insert the device into the vagina at all. Participants were asked if they believed that the SILCS was correctly positioned, or not, based on the written instructions which indicate that if the cervix is not covered or there is discomfort the diaphragm is not in the correct position. The technician then examined the placement to determine correct positioning according to 4 criteria: cervix covered, device behind pubic bone, device not protruding, and comfortable to use as per the participant. If the participant was not able to correctly position the device on the first try and the clinician was able to achieve correct positioning, then the participant was allowed up to two more chances to insert and remove the device with additional instructions, in order to be able to prove competency with this procedure to continue in the study.

(4) Data: To date, 418 records for the fitting assessment were accessible from the database of 450 potential records. The participant was able to insert the device into the vagina on the first try in 385 of 418 fittings (92%). The device was correctly positioned in 326 of 385 (85%) based on clinician assessment. The 59 (15%) devices were incorrectly positioned for the following primary reasons: not behind the pubic bone (31), SILCS not covering the cervix (17), protruding (7), upside down or backwards (3), and no reason identified (1). Of the 59 incorrectly positioned devices, 6 were identified by the participant as being incorrectly positioned but 53 were felt by the participant to be correctly positioned. Thus 53 of 385 (14%) women purchasing the device in an over-the-counter setting might be able to insert the device but not recognize that it was incorrectly positioned. The clinician was able to confirm a good fit with 407 of 418 (97%) devices, including the 326 participants who achieved a good fit on the first try, 52 of the 59 (88%) participants who incorrectly positioned the device on the first try, and 29 out of 33 (88%) who were unable to insert the device.

(5) Findings: These preliminary data show that the device fit almost all of the participants based on established fitting criteria. If the diaphragm was purchased over-the-counter, a small percentage of women would be at risk for using a device that was not correctly positioned due to an uncovered cervix or protruding device which could put them at an increased risk for pregnancy. Improved instruction on correct positioning will be developed on the basis of these results.

(6) Knowledge Contributions or Lessons Learned: The clinician and user experience from this study will help guide the user instructions for the marketed product, if the trial supports licensure.

E01: 4 Development and Acceptability of the NES/EE CVR: A Year-Long, User Controlled Contraceptive Method
Ruth Merkatz, Regine Sitruk-Ware, Irving Sivin, Barbara Mensch, Paul Hewett, Michael Cooney, Elena Hoskin
Population Council, Center for Biomedical Research, United States of America; rmerkatz@popcouncil.org

1. Background/Significance: In 2007, 1.7 billion women were in need of contraception, but only 57% were using modern methods (1). The continuing high rates of maternal mortality in the developing world require continued focus and a wide array of interventions, including provision of contraceptive services that provide methods acceptable to women and men throughout their reproductive life cycles (2). To that end, the Population Council (PC) has continued its longstanding effort to develop and gain regulatory approval for methods that may reduce the unmet need for contraception. Currently PC is completing development of a long acting hormonal contraceptive vaginal ring (CVR) that contains Nestorone® (NES) a new non androgenic progestin, and ethinyl estradiol (EE). This novel user-controlled CVR, which may be used for 13 cycles (one year), offers women a unique combination of convenience and fertility control. The woman inserts and removes the CVR herself, using the ring for three weeks and then removing it for one week during which time monthly bleeding occurs. There is no need to refrigerate the CVR. Women are instructed to keep the ring in a safe place and to wash it with water after removal and before reinserting.

2. Research Questions: The main objective of this Phase 3 trial was to determine if the NES/EE CVR is safe and effective during one year of use. Secondary objectives were to evaluate cycle control return to fertility, and side effects. There was also an acceptability study designed to identify characteristics of the CVR that appeal to (or are problematic) for women and their partners as well as characteristics of women who are satisfied and successful users of this CVR. Such information, which is used by policy makers who make procurement and distribution decisions, health care professionals who influence women’s contraceptive choices, and women themselves seeking to make informed decisions about contraception, is critical for successful introduction of a method into diverse regions of the world.

3. Methodology: The Phase 3 clinical trial program included 2 pivotal studies: one supported by the NIH (NICHID) with 15 sites in the US, and a second (international study) supported by USAID and WHO with 12 sites located in Latin America, Europe, Australia, and the US. Efficacy is to be determined by the pregnancy rate using the Pearl Index. Cycle control is described as days of scheduled/ unscheduled bleeding. Safety is evaluated by collecting information on serious adverse events (SAEs) and adverse events (AEs). Participants’ well-being was monitored including effects on weight, blood pressure, hemoglobin, blood chemistry as well as effects on the vagina and endometrium. Acceptability, which was operationalized in terms of satisfaction, ease of use, perception of side effects and effects on sexual activity, was measured through a questionnaire administered twice during the study. Participants were randomized to a face to face (FTF) or audio computerized assisted interview (ACASI).

4. Data: A total of 2277 women were enrolled in the two studies at 27 international and US sites. The overall continuation rate was ~60 % (rates varied by region). Data for the acceptability study were collected from 1035 women who participated in the international study.

5. Findings: While safety and efficacy data analyses are not yet complete, a preliminary review suggests the CVR is highly effective in preventing pregnancy when used as directed, has a safety profile comparable to those of other combined hormonal contraceptives, and provides rapid return to fertility. Findings from the acceptability study reveal the vast majority of women were highly satisfied, found the CVR easy to use and it did not detract from their sexual activity. Women also reported that while 55% of their partners felt the ring during intercourse, most (80%) did not report negative effects on sexual pleasure. Using a logistics regression model to compare acceptability scores among women who discontinued early vs. those who completed a full year, we found more complaints about side effects, difficulty remembering to reinset the CVR on schedule, frequent removal of the ring prior to intercourse and complaints about feeling the ring were significant factors. Logistics regression modeling also revealed a significantly increased likelihood of becoming pregnant in women who reported a higher incidence of feeling the ring, removing the ring (including for sexual activity), as well as being younger in age and having higher gravidity. There were significant differences in responses to sensitive questions based on interview mode (FTF vs. ACASI).

6. Research Knowledge Contribution: If this CVR is approved and made available, it will provide another method choice that most users are likely to find satisfactory. Since only one ring is required for a full year, it can provide added user convenience and potentially reduced costs. The method also has potential to reduce initial introductory costs as technically skilled, specially trained health workers are not required for insertion or removal of the ring.

E01: 5 Increasing access to injectable contraceptives: Introduction of depo-subQ provera 104™ in the Uninject® device
Sara Jane Tiff, Jane Hutchings
PATH, United States of America; stiff@path.org
1. Background/Significance:
Injectable contraceptives are among the world's most popular methods for preventing pregnancy because of their safety, efficacy, convenience, and privacy. The UNFPA estimates that global demand for injectable contraceptives will increase 30.9 percent by 2015.

Increasing access to injectables and improving continuation may benefit from approaches that enable (1) non-clinical access, and (2) more delivery by less trained health workers and community agents.

A new subcutaneous formulation of Depo-Provera®, packaged in the Uniject® device is expected to be available in mid-2011. The Uniject device is a small, autodisable injection system. The product in this delivery system is called depo-subQ provera 104™ (depo-subQ) in Uniject. The single, prefilled delivery device with subcutaneous needle may offer the potential to increase the effectiveness and efficiency of injectable contraceptive storage, distribution, training, delivery, and disposal. Use of depo-subQ in Uniject may strengthen the feasibility of non-medical personnel providing injectable contraceptive services outside clinics and home based contraceptive injection use.

2. Program: State intervention/activity tested
A thorough and systematic understanding of the environment affecting total market introduction of depo-subQ in Uniject will lead to development of sound, feasible, and effective product introduction plans. These introduction plans will be the basis for successful country-level product introduction and scale-up to increase access to injectable contraceptives.

3. Methodology (including location, setting, period, analysis approach)
Successful country-level product introduction is an iterative process that fully engages key stakeholders and partners from the government, NGO, and commercial sectors. Successful introduction strategies address all market conditions that affect the product and its purchasers and users, as well as the systems that deliver the product. Factors include policies, regulations, service delivery requirements, demand, procurement and delivery logistics, costs, and financing.

PATH followed a three-step process to identify introduction countries for depo-subQ in Uniject, selecting for countries which present these conditions for success and which demonstrate a strong commitment to expanding the use of depo-subQ and introducing a new product. The assessment process steps were:

1. Rapid assessment of sixteen candidate countries.
2. Selection of eight countries from the sixteen initial candidates, based on criteria linked to successful introduction.
3. Conducting a broad based stakeholder-interest assessment in eight countries to identify product introduction opportunities and barriers.
4. Conducting a comprehensive assessment to develop total market introduction plans and strategies.

In step 1, PATH developed profiles of sixteen candidate countries and selection criteria by assessing the following:
- Population, MMR, TFR, CPR.
- Modern method CPR, method mix, changes in injectable use vs. other methods.
- Unmet need for family planning.
- Share of injectables provided by public, NGO, and commercial sectors.
- Method preferences.
- Innovative distribution or scale-up plans to expand injectable contraceptive access.
- National interest in total market approach.

Through a consultative process with global experts, PATH selected the following eight countries for initial in-country assessment:
- Ethiopia
- Kenya
- Rwanda
- Malawi
- Senegal
- Nigeria
- Pakistan
- Bangladesh

PATH also conducted a rapid online survey to gauge general interest in the product. Fifty-three respondents from thirteen countries participated and indicated strong interest in depo-subQ in Uniject. The respondents indicated an expectation that depo-subQ would increase use of injectables in non-clinical settings as well as delivery by less trained workers.

PATH technical teams completed eight country assessments from April through August 2009. Each assessment included meetings with relevant informants and stakeholders to assess:
- Potential for successful national introduction of depo-subQ in Uniject.
- Specific introduction strategies.
- Potential to impact injectable contraceptive access and continuation rates.

Country-level informants represented:
- Donor agencies.
- Ministries of health.
- Drug regulatory, health service delivery, and injection policy bodies.
- NGO and commercial distribution groups.
- Medical, nursing, and pharmacy interests.
• Government drug logistics and supply agencies.
• Product manufacturers.
• Government and NGO health service delivery entities.

After completion of the eight assessments, PATH will select five countries for in-depth national introduction planning based on assessment results and consultation with advisors.

4. Data (if relevant)
• Secondary data compiled and evaluated through research and interviews.
• Primary and secondary data collected through interviews, focus group discussions, and observational data.

5. Findings
The rapid survey indicated high levels of interest in the product. Respondents believed that the product would increase access to injectable contraceptives by increasing the number and types of providers and outlets where the method may be delivered.

Country assessment findings to date suggest inhibiting and constraining factors for introduction of depo-subQ in Uniject, plus factors to be monitored. The synthesized findings from the eight country assessments are expected to indicate the conditions for and locations of countries where in-depth introduction strategy development and planning can take place and lay the groundwork for implementation when the product is commercially available.

6. Knowledge contribution or lessons learned
PATH’s experience developing systematic, comprehensive, and multi-disciplinary approaches to country-level introduction of depo-subQ in Uniject will contribute to product introduction knowledge and experience for contraceptives and for other products.

F01: Effective Programming and Service Delivery

Time: Monday, 16 November 2009: 9:30am - 11:00am

F01: 1

Client and Provider Perspectives on Barriers to Family Planning Quality in Kenya: Assessment and Programmatic Implications

Constance Ambasa-Shisanya1, C Homan1, J Alai2, C MacKenzie1, B Kigen1, A Njeru2, C Mutunga2
1Family Health International, Kenya; 2Division of Reproductive Health, Ministry of Health, Kenya; cambasa@fhi.org

Background

This paper examines unmet need for family planning (FP) in Kenya with focus on barriers to quality of services at clinics. Historically, there has been an increase in contraceptive prevalence rate (CPR) among married women in Kenya from 7% in 1997/78 to 39% in 1998. The CPR stagnated at the same level in 2003 and total fertility rate (TFR) increased to 4.9. 40% of new users discontinue their method of choice within the first year of use. This high discontinuation rate may be indicative of quality issues in the provision of FP services.

Existing data from other contexts demonstrate that good quality FP services encourage clients to seek services. Furthermore, provision of information about side effects results in continuation of contraceptive use even when clients experience side effects. An assessment of the quality of FP counseling was undertaken to inform improvement in communication between clients and service providers.

Study Design

The study was conducted in four health facilities in the Rift Valley Province of Kenya: Nakuru Provincial General Hospital, Naivasha District Hospital, Uasin Gishu District Hospital and Huruma Health Center. The study was designed in three phases. First, an assessment of current FP practices in selected facilities was undertaken. A lexicon was to be developed comprising of words and concepts that are consistent with FP clients’ language to revise the balanced counseling strategy (BCS) tools developed by the Population Council. Second, service providers and supervisors were to be trained to implement an improved BCS for three months; and third an evaluation of the intervention was to be conducted. This presentation will focus on the results of the assessment and how the results are being used to improve the quality of client-provider interaction.

Methods

Six methods were used to collect data: exit interviews with 256 FP clients; 14 informal group discussions with returning clients; 12 in-depth interviews with providers and supervisors; observation of 88 provider/client interactions; abstraction of data from clinic registries and recording of provider encounter logs for two weeks. Quantitative data were edited, processed and analyzed using SPSS. This data was limited to descriptive analysis. Qualitative data were transcribed, coded using the Nudist 6 program and analyzed using Nvivo 7 program.

Results: Regarding quality of FP counseling, information on the following aspects was provided: advantages of the method received (68%); disadvantages of the method received (63%), how to use the method (73%); method suitability (62%), potential side effects of the method (63%) and comprehension of words used to counsel (93%). Clients’ perspectives on barriers to FP provision include: lack of assertiveness to seek relevant information on available contraceptive methods and side effects; perceived provider disposition which make interaction difficult, financial constraints; and group counseling which denies them privacy. Providers’ perspectives on barriers to FP quality include: staff shortage; heavy client load; inadequate space/room, competing integration requirements; inadequate skills; insufficient commodity supply and equipment shortage.

Conclusions: There has been an improvement in the quality of FP service offered to clients in the recent past with over 62% of clients reporting provision of adequate information compared to previous evidence where less than 50% were adequately counseled on side effects of their current methods (Mensch et al., 1994; Kim et. al., 1998). Most FP clients (93%) understand the language used during counseling. However, many clients remain passive during counseling sessions resulting in unaddressed concerns and issues. Additionally, other personal, structural and organizational barriers hinder provision of good quality services.

Programmatic Implications: The assessment revealed a need for client empowerment to facilitate a productive interaction with the provider. The intervention will therefore endeavor to empower the client to actively engage the provider during counseling sessions. Topically colored cue cards will be placed in client waiting areas in envelopes on a poster with a message: “It’s your visit, what would you like to discuss?” The poster will direct the client to select one or more cards and carry these with them into the counseling room to alert the provider on issues most important to the client. The provider will be able to discern from the color of the card carried by the client and focus the counseling session to respond to client needs. The topics on the cards include: method suitability,
management of side effects, duration of method use, communication of FP issues with sexual partner and any other concerns. The BCS will be used for systematic counseling.

F01: 2

Evaluations of the impact of quality of care interventions on clients’ behaviors in three countries
Ian David Askew
Population Council, Kenya; iaskew@popcouncil.org

Background / significance:
A high quality of care during the provision of family planning services is regarded as both a basic right for clients and also as a factor that enables clients to better achieve their reproductive intentions. A state-of-the-art review published in 2003 summarized what was known about the relationship between quality of care and use of family planning services and highlighted key gaps in our understanding. One outcome of this review was the realization that very few studies have been undertaken that systematically evaluate the effect of interventions to improve quality of care, and the extent to which improved quality of care affects clients’ behaviour. This paper presents the findings from three rigorously-implemented research studies completed subsequent to this review (in Egypt, Peru and Uganda) that contribute further knowledge to our understanding of the role of quality of care in family planning programs, and in particular its effect on service utilization and client behaviours.

Main research questions:
These three studies addressed the same three questions: i) can context-specific interventions be developed that both strengthen system readiness and enhance clients’ rights to receive quality care; ii) can these interventions make measurable improvements in the process and content of client-provider interactions?; and iii) if quality of care is improved, what is the effect on client outcomes?

Methodology:
The research design used a two-stage model. The first stage documented systematically the design and implementation of the quality improvement interventions and then sought to assess whether the interventions made measurable and significant improvements in client-provider interactions. Districts in each country were purposively selected and matched and then randomly assigned to experimental and comparison groups; a sample of clinics in each district were then randomly selected for inclusion in the study. Before and after measures of the quality of client-provider interactions were made in both groups of clinics using observations of family planning consultations, interviews with samples of clients and providers, an inventory of each clinic’s readiness to offer quality services, and abstraction of service statistics to describe service utilization.

Undertaking the second phase was dependent on the first phase demonstrating a significant improvement in the quality of client-provider interactions, which was only achieved in two of the countries (Egypt and Peru). In these countries the studies went on to evaluate the impact of these interventions on client outcomes using a longitudinal study design to follow cohorts of approximately 300 new-event users recruited from the experimental and control clinics. The quality of the client-provider interaction was observed on recruitment and the clients were interviewed on exit and at two further points in times. The key outcome indicator was a comparison between the groups in terms of 12-month continuation rates.

Data / findings:
Women in the experimental groups were more knowledgeable than those in control groups about their chosen method.
About one quarter of women in both groups switched method during the 12-month period.
Women in the experimental groups were more satisfied with the service and method than those in control groups.
At 12 months, 71-75% of women in Peru and 83-86% of women in Egypt were still using family planning.
There were no differences in the all-method12-month cumulative continuation rates between experimental and control groups (66-68% in Egypt; 44-48% in Peru).

Lessons learned:
These studies demonstrated that activities to strengthen clinic readiness to offer quality of care are well understood, but may not lead to major or sustainable improvements in care. Contraceptive updates lead to small improvements in provider knowledge, and are especially useful if existing knowledge is poor. Provider motivation was found to be critical to improving client-provider interactions and can be improved through ensuring better working conditions. Job aids can help with provider communication and client understanding.

On average, there was little difference in continuation rate, which questions whether the goal of efforts to improve quality of care should be an effect on service utilization. It is important to bear in mind, however, that these results reflect ‘average’ experiences, both of the service provided/received and of the clients’ behaviors. Whether continuation rates are an appropriate indicator of effectiveness can be questioned, given that it is method dependent and that discontinuation can be due to a change in a client’s reproductive intention change as well as their experience of the service quality. Moreover, “good” quality of care is acknowledged recognized as a client’s right and so whether there is a need to evaluate its effect on utilization and behavior is questionable. Perhaps the more important question is whether there is a minimum standard of quality below which services should not be offered.

F01: 3

Impact of Exposure to Family Planning Interventions on use of Modern Family Planning Methods in Nigeria
Samson Babatunde Adebayo, Richard Fakolade, Chinazo Ujuju, Jennifer Anyanti
Society for Family Health, Nigeria; sadebayo@sfhngigeria.org

Background
The Society for Family Health (SFH) is one of the leading and largest public health Non-Governmental Organization in Nigeria. One of the strategies to improve reproductive health in the country is through the Improving Reproductive Health in Nigeria (IRHIN) project funded by United States Agency for International Development (USAID). The thrust of the project is to improve the understanding of, access to, and correct use of contraceptives with the aim of reducing unintended or mis-timed pregnancies.

Intervention
The intervention carried out by Society for Family Health in Nigeria focused on an integrated approach to reproductive health programming. This involves strengthening of health centres and hospitals in selected sites, to provide a wide range of family planning (FP) products and services. It also serves as referral
points to smaller clinics and a collection point for service statistics. This was also meant to provide support to smaller community clinics, and strengthening of Civil Society Organizations (CSOs) in order to mobilize communities and help to increase knowledge and use of family planning products and services.

Methodology

A quasi-experimental design was employed to evaluate impact of this intervention strategy. This design is suitable for measuring programme impact particularly when a new intervention strategy is introduced into an area against a similar neighbouring area as the control site. The survey was used to compare the level of improvement in the quality of reproductive health services among women of reproductive age (15-49 years) who have been exposed to IRHIN interventions with those of equivalent characteristics in the control communities. A multi-stage cluster sampling procedure was used for selecting the eligible respondents in the survey.

Data

Based on appropriate formular and with the intention of detecting a 15% change in major indicators, a minimum sample size of 900 eligible respondents was obtained for each of the intervention and control communities giving a total sample size of 1,800 respondents for the survey. Possible impact of exposure to intervention was investigated through bivariate and multivariate analyses.

Findings

At the bivariate level, the proportion of those who are currently using modern family planning methods in the intervention site was 34.3% compared to 26.9% in the control site. This was significant with a P-value of 0.001 from Chi-square test. At a multivariate level, logistic regression analysis was used to explore possible association between exposure and use of modern family planning method (without controlling for other factors). Women who were exposed to intervention were about 1.4 times more likely to use modern family planning method compared with their counterparts in the control sites. At a further stage of analyses, possible determinants of use of modern FP were adjusted for in the logistic regression. Again, women who were exposed to intervention were about 1.6 times more likely to use modern FP method. Goodness-of-fit of the model was based on Hosmer and Lemeshow statistic; revealing a good fit with p-value of 0.421. This implies that the model fits the data very well.

Lessons learnt

The intervention led to an increased use of modern FP method among the respondents in the intervention sites compared with those who were in the control sites. This shows that the intervention was effective in increasing use of modern FP. Scaling up such interventions should be given adequate attention in other communities with the aim of increasing uptake and adoption of modern FP method.

F01: 4

District Participation in the selection of Project target zones for delivering Family Planning Services in Uganda

Elke Koning1, Paul Hamilton1, Henry Kakande1, A. SK Nabatanzi1, Anthony Mbone2

1Management Sciences for Health, Uganda; 2Ministry of Health, Uganda; ekonings@msh.org

1. Background/Significance

While other African countries have seen major improvements, Uganda’s high fertility rate (6.7), maternal mortality (435/1000) and child mortality (137/1000) have remained virtually the same for more than a decade. The reasons, among others, are related to a disproportionate focus on HIV/AIDS, Uganda’s pro-natalist culture and politics, and past program failures. To redress the imbalance in health programming and achieve notable fertility and mortality improvements, new and different implementation methods are imperative, beginning with a renewed focus on family planning and child survival services, and the way in which donor funded projects decide on the target districts. To date, these districts are most often selected by central government officials and donor representatives without the districts themselves having any input in the decision. As a result, already under-resourced local authorities in the selected districts become the passive recipients of technical assistance (TA), with few – if any- incentives to support project implementation.

2. Research: State main question/hypothosis

Program: State intervention/activity tested

To maximize health results, districts must be encouraged to participate in their selection as a project implementation site. By actively participating and promoting their own selection, target districts show their motivation to become project beneficiaries and they become accountable stakeholders to both their constituencies and their TA partners for program success.

3. Methodology (including location, setting, period, analysis approach)

The new USAID-funded project “STRIDES for Family Health” introduced a transparent, competitive process of selecting up to 15 districts to improve the availability, quality and use of reproductive health, family planning and child survival services. Together with the Ministry of Health, the project invited all Ugandan districts not yet benefiting from donor support for family planning, to express their interest to be selected for project implementation. The request included detailed information on eligibility criteria; proposal preparation instructions; a short questionnaire covering (a) a limited number of district’s health indicators, (b) health systems and functioning of district management teams, (c) the district’s motivation for and reasons why it should be among the implementation districts; clear, verifiable evaluation criteria; and a description of the review and selection process. The evaluation criteria focused heavily on district motivation to work with the project, their willingness to enter into partnerships with the private sector, their ability to access community networks and their openness to innovation. However, the evaluation also took into account the district health needs such as unmet need for family planning and health management issues. After issuing the invitation for expressions of interest, the project organized small meetings with district representatives of 5 districts each to review and discuss the project objectives, the benefits and expectations of participating in the project, the process of district selection, the way that the questionnaire needed to be filled out and how districts could maximize their chances of being selected. The due date for submission is 12 June 2009, and districts will be selected by 30 July 2009.

4. Data (if relevant)

5. Findings

Both central and district Ministry of Health officials welcomed this new process of selecting target districts for project implementation because it encouraged transparency and accountability on the part of both the project and the districts.

In-person follow-up to explain to the district officials how and why they can compete for selection in the project was the catalyst for many districts to proceed to developing and submitting an expression of interest; these stakeholders’ meetings also served as an opportunity for capacity development in good management practices including the need for transparency and accountability, proposal preparation and awareness raising of family planning and other neglected health services.
Findings will be presented on the response rate, the profile of the selected districts and on the opportunities and challenges of project start-up activities in the selected districts. This will be compared to other projects that are being implemented in pre-selected districts that had no opportunity to participate in the selection process.

6. Research: State knowledge contribution

Program: State lessons learned

Early engagement of potential project implementation sites not only creates ownership and sustainability, but accountability and transparency.

A competitive process to select project implementation districts encourages districts to become active stakeholders in the project’s success rather than passive recipients of donor funded technical assistance

A clear, well defined set of criteria for district selection also serves as a public and upfront statement of the project’s basic operating principles including, in this case, the importance of community networks, public-private partnerships, and innovation.

A district’s openness about its weaknesses/low performance, and its interest in improving these should be considered a strong point for selection.

F01: 5

Increasing Couple Years of Protection (CYP): Successful Strategies from a Community-Based Family Planning Program in Uganda

Heather Lukolyo, Paige Anderson Bowen, Pamela Mukaire, Laura C. Ehrlich, Diana K. DuBois

Minnesota International Health Volunteers, United States of America; lehrlich@mihv.org

Background

Since 2006, Minnesota International Health Volunteers (MIHV), a U.S.-based private voluntary organization (PVO), has implemented a U.S. Agency for International Development (USAID)-funded community-based family planning program in two districts of Central Uganda. The MIHV program addressed family planning within the larger context of reproductive and maternal health using a multi-sectoral, community/participatory approach.

Intervention

Working collaboratively with PVOs, district officials, and other stakeholders, MIHV employed the following principle strategies to facilitate access to family planning services at multiple levels within the context of its program:

1. Expanding service delivery by enabling a range of providers (public sector, private sector, community volunteers trained in family planning, traditional birth attendants) to deliver family planning information, referrals, and services;
2. Piloting alternate delivery mechanisms for medium- to long-acting family planning methods through a satellite clinic approach to allow implant insertion in remote areas and by equipping community health workers with the knowledge, skills, and support-supervision to administer Depo Provera at the community level;
3. Educating and mobilizing communities to increase demand for, and use of, family planning services;
4. Building the capacity of health unit staff to mobilize communities, understand contraceptive commodity logistics, supervise health workers and community health workers, establish referral systems, improve client counseling, and create realistic budgets and plans;
5. Collaborating with other stakeholders including PVOs, agencies, and others at the district- and national- levels to leverage resources and increase access to family planning services;
6. Engaging men and opinion leaders including religious leaders to advocate for and support family planning;
7. Developing innovative information, education and communication methods to deliver family planning messages to low literate and hard-to-reach populations.

Methods

Family planning data on contraceptive methods provided was collected by MIHV staff semi-annually from the district health management information system (HMIS) and quarterly from community health workers’ register books. Couple years of protection (CYP) were calculated using standard measures. Additionally monitoring data was regularly recorded for program education and outreach activities using program-developed standardized forms.

Data

Between 2007 and 2008, CYP resulting from family planning dispensed at government health units, including MIHV-supported family planning outreaches, increased from 3,978.6 (1,342.6 in Ssembabule and 2,636.0 in Mubende) to 5,487.0 (2,256.4 in Ssembabule and 3,230.6 in Mubende). During the same timeframe, CYP resulting from family planning dispensed by MIHV-trained family planning community health workers at the community level increased from 523.6 (301.3 in Ssembabule and 222.3 in Mubende) to 924.7 (108.1 in Ssembabule and 816.6 in Mubende). Overall, a nearly 50% increase in CYP (from 4,502 in 2007 to 6,411.7 in 2008) was seen.

Findings

The reported increase in CYP can be attributed to the following program outcomes achieved in Phase One of the project (2006-2008).

1. Expanding service delivery
   - 265 trained FPCHWs reached 24,617 clients with FP services
   - 9,126 clients referred forFP services by FPCHWs
   - 78 private practitioners received FP refresher training

2. Piloting alternative delivery mechanisms
   - 3,448 community members received satellite FP outreach services – counseling and method distribution (condoms, pill cycles, injectable, implants, Standard Days Method)
   - 40 FPCHWs trained in community-based distribution of Depo Provera

3. Educating and mobilizing communities
   - FPCHWs reached 185,731 people with FP messages delivered at health talks
   - 7,760 people mobilized during 13 FP Days
6,954 individuals reached with FP messages at film shows (31,584 condoms distributed)
40,000 people reached through 8 FP radio call-in programs
6,955 people reached through district events, drama shows, and staff-led health talks

4. Building the capacity of health unit staff
   45 health unit staff trained in FP logistics management

5. Collaborating with other stakeholders
   Initiation of district-level Family Planning Implementation Teams
   Active participation in FP Revitalization Working Group and CBD of DMPA National Core Team
   Co-chair of the CBFP Consortium in Uganda

6. Engaging men and opinion leaders
   Of two FPCHWs recruited and trained per parish, at least one is a male
   Location, timing, and focus of FP mobilization and education events strategically chosen to target men
   61 religious leaders reached with FP sensitization training; additional 19 participated in development of FP action plan

7. Developing innovative IEC methods
   Radio call-in programs on key FP topics
   FP Days: large-scale community mobilization events centered on FP
   FP films shown at community gathering places; program staff, health unit workers and FPCHWs provide FP counseling and referrals, answer questions, and distribute condoms
   Annual calendars with photographs depicting key FP messages and text in local languages

Knowledge Contribution
While it is difficult to attribute the demonstrated increase in CYP to any one activity or strategy, the key elements leading to the success of MIHV’s ongoing community-based family planning program can be used as a model for other PVOs, government entities, and others working to develop successful family planning programs in similar resource-poor environments.

P1: Poster Session 1: Expanding Contraceptive Access to Populations with Need

P1: 1

The Impact of Unmet Need and Discontinuation on the Total Fertility Rate: An Assessment to Inform Public Policy in Jordan
Douglas Heisler
Futures Group International, Jordan/Health Policy Initiative, Task Order 1; dheisler_mailbox@yahoo.com

1. Background/Significance: After a decline from 7.4 in 1976 to 3.6 in 2007, the total fertility rate (TFR) appears to have reached a plateau in Jordan. To meet the reproductive goals of couples, and to slow population growth in order to enhance the context for development, the government of Jordan (GOJ) is considering actions to reduce unmet need for family planning and to reduce contraceptive discontinuation.

2. Research: State main question/hypothesis: What is the impact on the TFR of reducing unmet need and discontinuation in Jordan? Should the GOJ focus increased family planning efforts to reduce unmet need and discontinuation in targeted geographic areas and/or among selected components of the population?

3. Methodology (including location, setting, period, analysis approach): The research, conducted in Jordan from January-June 2009, was based on estimates of differences in unmet need (95% CI); logistic regression; and cumulative incidence estimates in the presence of competing risks. The authors compared unmet need in urban and rural areas, among the twelve governorates, and the differences in unmet need by age, parity (CEB), Education, and wealth quintile. One year discontinuation probabilities by competing risks (desire to become pregnant, method failure, switching and other) were also computed for the same background variables.

4. Data: The 2007 Jordan Population and Health Survey (JPFHS 2007), conducted by the GOJ Department of Statistics and Macro International, was a representative sample of 14,564 households including 10,354 currently married women age 15-49. Analysis was based on the JPFHS 2007 Individual Women’s Recode File and an Events File that Macro International created for this study from the JPFHS 2007 five-year reproductive calendar.

5. Findings: A successful public program addressing unmet need might reduce the TFR from 3.6 to 3.1, or slightly less depending on the method mix. Efforts to reduce TFR by addressing discontinuation will depend on a decrease in the high demand for children. But a successful program is expected to improve the lives of selected women in selected target areas who have a high unmet need for family planning and who experience discontinuation due to method failure. The authors recommend that the GOJ should promote comprehensive improvement across the public health system in the availability and quality of counseling and increase the level and quality of information about family planning available to consumers and providers; test this approach in a pilot activity in a poor urban area; design and scale up effective interventions at the national and regional level; and expand the Ministry of Health’s pilot sentinel surveillance on discontinuation.

6. Knowledge contribution: Depending on the context, addressing unmet need for family planning and contraceptive discontinuation may not result in a dramatic reduction in fertility. As public officials assess the option of targeting programs to geographic areas or selected population components, they should not only consider the expected impact at the national and family levels, but also bear in mind the issues of equity and administrative feasibility.

P1: 2

What are the Changes in the Contraceptive Pattern and Behavior in the Process of Fertility Transition of China? 1988-2001
Xiaoying Zheng, Qiang Ren, Lei Zhang, Zhijun Cui, Quyuan Chen, He Chen
Institute of Population Research/WHO Collaborating Center of Reproductive Health and Population Science, China, Peoples Republic of; xzheng@pku.edu.cn

1. Background/Significance Since the 1970s, the population of China increases 20 million every year. The rapid growth of population makes the population increased from the 550 million in 1950 to 830 million in 1970. Based on the actual conditions of China, the central government adjusted and implemented new
population & family planning policy in early 1970s. Since 1980s, China’s high fertility has been transferred to low fertility, while the contraception level of the married reproductive people has always maintained at the high level. The latest report shows that contraception prevalence in China is still staying at 90%, a rather high level. State intervention/activity tested During the past 30 years, the married reproductive people have implemented long-term or short-term contraceptive methods according to the different family scale to effectively curb the rapid growth of the population.

2. Research: State main question/hypothesis
Program:
This paper mainly explored the salient features of the contraceptive pattern and behavior of Chinese married reproductive people and the factors accounting and furthermore the spatial-temporal changes of the contraceptive pattern of the married reproductive people by age, children-ever-born, and the living environment. Also, this paper studied whether people desired to choose the medical-controlled contraceptive method or self-controlled contraceptive method in the condition of more freeness to choose a kind of contraceptive method since the practice of informed choice in family planning work. In short, the purpose of the paper is to understand the transferring process, content and regional difference of the contraceptive pattern and behavior during the course of China’s population transition and the realization of the low fertility, and the contraceptive pattern of the married reproductive people since the practice of informed choice in family planning work in 1994. And to make it possible to predict the trend of the future changes of the contraceptive pattern under the circumstances of low fertility level.

3. Methodology (including location, setting, period, analysis approach)
4. data (if relevant)
The data of this study come from the NBCSS conducted by the State Population and Family Planning Committee in 1988, 1997, 2001, 2006. All these three surveys included the contraception history of the women.

5. Findings

the contraceptive pattern of the reproductive people only had experienced little changes from the 1990s to the beginning of this century. The proportion of the married reproductive people who chose the medical-controlled contraceptive methods in China exhibited a fluctuating trend of “rise to fall”, which were 87.3%, 92.6% and 90.6% respectively in 1988, 1997 and 2001, while the proportion of the people who chose self-controlled contraceptive methods experienced a fluctuating trend of “fall to rise”, which were 12.7%, 7.4% and 9.4% respectively. A tremendous change had taken place in male contraceptive methods. The proportion of male sterilization dropped from 12% in the early 1990s to 7% in 2004, while the proportion of the condom rose from 4% to 6%. In the middle of the 1990s when concept of the family planning changed, some salient features occurred in the trend of the use of the contraceptive methods. After the proportion of male sterilization hit highest in 1992, it declined slowly year by year, and so to female sterilization of which the proportion was highest in 1994. On the contrary, the proportion of the married reproductive people who choose medical-controlled methods showed a trend of rise. There were changes in contraceptive pattern in these trial sets, they could have little influences on the whole country. And therefore it is impossible to see the changes in the contraceptive pattern in such a short period after the implementation of informed choice. The proportions of the people used medical-controlled methods were 87.3%, 92.6% and 90.6% in 1988, 1997 and 2001 respectively, the change from 2006 is not significant. The corresponding figures of the self-controlled methods were 12.7%, 7.4% and 9.4% and 10% respectively. It displayed a trend of the increase of the medical-controlled methods with the drop of self-controlled methods. Contraceptive pattern of the married reproductive people of the Han is significantly different from that of the minorities.

6. Research: State knowledge contribution
Program: State lessons learned
The selection of the contraceptive methods of the Chinese married reproductive people had already formed some certain regular pattern, which directly related to the contents of family planning programmes advocated by population policies. During the ten years after the implementation of reproductive health project, the contraceptive behaviors and patterns had experienced some but not fundamental changes, say, only some slowly and unclear changing trends in the transition of contraceptive pattern. Because the formation and transition of contraceptive pattern is a result of the actions of the determinants after a long time, so we need more time to observe the changes of the Chinese contraceptive patterns, and furthermore, we can obtain more convincing evidence to examine the relationship between the introduction of reproductive health projects and the contraceptive pattern.

P1: 3

Human Security and Sexuality in the IPPF Africa Region

Patrick Orutin, Cheick Ouendarao, Tewodros Melesse
International Planned Parenthood Federation Africa Region, Kenya; porotin@ip faro.org

Background
The concept of human security (HS) and its linkages to sexual health is gaining importance in human development. HS refers to analyzes of relationship between vulnerabilities and poverty. For example, the Millennium Development Goals (MDG) cannot be achieved without addressing sexual rights of PLWAs; for basic human rights, political security need to be guaranteed; sexual health and rights can only be guaranteed through respectful approach to sexuality; without mechanisms to address uneven distribution of resources, poverty and disempowerment, there cannot be an enabling environment to promote universal access to sexual and reproductive health. Thus, holistic approaches to health and development, including the concept of HS will provide a framework within which to view Africa’s development. HS forms an important part of people’s well being, and thus a need for stock-taking what is known for provisional guidance on the development of HS within the SRHR programming, and in order to identify issues in need of resolution.

In response to this, a study was conducted between November 2008 and April 2009 in the DRC, Angola, Liberia and Uganda, selected for their worst experience in human insecurity. This study sought to i) derive lessons from policy initiatives and interventions that include SRHR as an element of HS; ii) initiate discussion within IPPFAR towards HS policy formulation that can be translated into guidelines for SRHR programming within Africa.

Key research questions addressed by this study were: i) How has HS been interpreted and used within the context of IPPFAR and other partners work? ii) What approaches, including policy initiatives have been used to promote HS in the IPPFAR? iii) What are the documented linkages, outcomes and impacts of HS on SRHR? iv) What are the lessons learnt regarding management of HS issues from the global and regional perspective? v) What approaches of HS are likely to be effective under the conditions prevailing in SSA and what are pitfalls to avoid? vi) How can this study allow IPPFAR to operationalize TICAD and other agreements that incorporate human security?

Methodology
The study approach utilised interview methods, on-site observations, success stories gathered using the Most Significant Change (MSC) methodology, Focus Group Discussions with groups of female, male and youth community members and Key Informant Interviews with partners and stakeholders in Angola, Democratic Republic of Congo (DRC), Liberia and Uganda. Data was analysed through content analysis and documentation of MSC stories. The following are key findings, conclusions and recommendations.

Findings

- HS approach has generally not been adopted by Member Associations in the target countries. Efforts to integrate HS approaches have mainly been reactive to existing socio-economic realities rather than a pro-active, conscious effort to focus on HS as a model for implementing IPPFARO programmes.

- Economic insecurity appears to be the most pervasive form of vulnerability facing communities within the IPPFAR. Competing economic demands make it difficult or impossible for SRHR target groups to prioritize reproductive health services in their household budgets.

- Poverty contributes to increasing vulnerability. Community, environmental, health and food insecurities perpetuate the situation further by affecting uptake of SRHR services by marginalized groups. War and conflict exacerbate existing forms of human insecurities further, affecting the achievement of IPPFAR's objectives in this area.

- Opportunities for adopting HS Approach in SRHR programmes exists as most Sub-Saharan Africa countries have developed poverty reduction strategy papers (PRSPs) which highlight a multi-sectoral approach to poverty reduction efforts. And HS approach fits well with the PRSPs.

Conclusions

- This study believes there is adequate justification for IPPFARO to pursue the operationalization of HS and Sexuality approaches to SRHR programming.

- The findings are clear on the potential benefits of this approach for furthering the goals of Sexual and Reproductive Health initiatives in line with the principles and guidelines expressed in the Maputo Plan of Action.

Recommendations

- IPPFAR needs to narrow the concept of HS into a more analytically tractable concept that prioritizes certain HS components over others. From this study, it appears that components like economic security, community security and health security seem to be having the greatest impact on the reproductive health of the people.

- The components of HS are diverse and require different skill sets to implement. IPPFAR should harness opportunities for collaboration and corporation that exist in the development community.

- The HS approach can cause a paradigm shift in the way that development programs are implemented, but not many people can actually define it or articulate what it entails. For IPPFAR to succeed in its collaborating partnerships, it needs to ensure that all collaborating partners fully understand the approach.

Lessons learnt

- Effective use of family planning services mitigates the effects of other human insecurities including economic insecurity, food insecurity, and health insecurity.

- The technical capacity of IPPFAR Member Associations cannot cope with HS in their programmes with the existing staff levels.

- Involving men in reproductive health activities including family planning is crucial if such interventions are to be successful. In all the countries visited men seem to have more influence in making family decisions thus interfering with personal security of their spouses.

P1: 4

Reproductive Health Supplies in Emergency Settings

Maaike van Min, Louise Lee Jones
Marie Stopes International (MSI), Belgium; maaike.vanmin@mariestopes-org.be

(1) Background/Significance

When people are forced to flee due to conflict or natural disasters, reproductive health (RH) needs are often a forgotten part of the emergency response, even though the needs are very high. Family planning, in particular is often not seen as a priority and many humanitarian agencies do not include RH supplies in their supply chain. The Reproductive Health Access Information and Services Initiative is a joint program developed by Marie Stopes International and the Mailman School of Public Health, Columbia University which aims to catalyze change in the way in which reproductive health is addressed from the outset of an emergency. Bringing together service delivery agencies and advocacy partners, RAISE is working to improve access to reproductive health services in Africa, Latin America and South East Asia and to influence the policy environment at international and national levels.

(2) Hypothesis or Intervention/Activity Tested

We believe that many of the challenges faced by organizations trying to support the provision of reproductive health services in conflict affected settings are common and that common solutions can be found. With little empirical data to support this theory we decided to examine the supply chain for three different projects supporting the provision of reproductive health services.

(3) Methodology

We conducted a desk based review of the gaps and opportunities for improving the availability of RH supplies in emergencies. Focusing on the role of key humanitarian and reproductive health actors, including WFP, WHO, UNHCR and UNFPA as well as larger humanitarian NGOs, we provide an overview of reproductive health supplies in emergencies. To complement this desk based piece of work, we conducted rapid assessments with three RAISE partners who are providing reproductive health services in conflict affected areas. Beginning in May 2009, a logistical consultant visited DRC, South Sudan and Uganda to conduct a rapid assessment of the RH supplies situation and to troubleshoot problems where possible. Semi structured interviews were held with project staff at the three sites, include logisticians, country directors and reproductive health coordinators. Also interviewed were relevant staff from the Ministry of Health, UN agencies and other NGOs operating in the area. Common themes were identified across the three projects and priorities for action agreed.

(5) Findings

Reproductive health supplies, in particular family planning supplies, were not, or not sufficiently, available in many of the family planning service delivery points visited. Some themes emerged from the three sites, as well as specific challenges faced by individual agencies or in particular settings. Common challenges faced included the lack of support to NGOs in ensuring RH supplies reach potential client at the health centre. Barriers exist at national, UN and NGO level. All NGOs visited were keen to improve the supply chain. In addition to presenting key findings from the assessments we will also present action taken to address the challenges identified.
P1: 5

KAP about Family Planning (FP) among currently married Afghan refugee women in reproductive ages, residing in Karachi Pakistan.

Hina Abdul Hamid Ladhha, Mehtab Karim, Sarah Saleem

The Aga Khan University, Community Health Sciences Department, Karachi, Pakistan; hina.ladhha@aku.edu

1. Background/Significance:

In a country where unstable political conditions and warfare prevail, the fertility level is usually high, which is mostly reflective of replacement behavior of couples who lose their children or fear to lose them due to prevailing conditions. Similar patterns are expected to be followed among refugees originating in the conflict zones, even when they have access to family planning services. During the Soviet invasion and even afterwards, due to unstable political and security environment in Afghanistan, over 3 million people migrated from Afghanistan to Pakistan. Of these, thousands of Afghan families were settled in Karachi city, with support from UNHCR and Focus Humanitarian, among many other organizations. The group which is supported by Focus Humanitarian also receives health coverage through a formal system whereby each family is registered and provided subsidized health care. Whereas, those supported by UNHCR do not receive health coverage, through any formal system and have to access services available to rest of the settled population. Several studies have shown that refugee women are at higher risk of facing reproductive health problems, and need individual attention. Experiments done by RAND show those individuals who get subsidized health care are likely to have better health indicators. However, no study has been conducted on refugee population, particularly regarding their knowledge and use of family planning services, Therefore, the objective of our study is to assess and compare KAP about family planning among the two groups of currently married Afghan refugee women residing in Karachi, Pakistan.

2. Research: State main question/hypothesis

We hypothesized that the women who get health coverage (group A) will have better knowledge and increased use of family planning services compared to the other group having no health coverage (group B).

3. Methodology (including location, setting, period, analysis approach)

For a cross sectional study design, systematic random sampling technique was employed to recruit the eligible subjects. Women in reproductive ages, who had been pregnant at least once in their lifetime, residing in proper housing in Karachi and who consented to participate were eligible to be the study participants. For the purpose about 350 women in each group were successfully interviewed during June-Aug’08. Multiple logistic regression analysis was used to analyze the data.

4. Findings

Findings of the study reveal that the mean age of the women in group B was 30 years (+/- 7.4 S.D) against 33 years (+/- 8.2 S.D) for women in group A. About 70% of women from group B were illiterate against 51% in group A. Women in group B were living in Karachi for over three years longer (mean 13.3 years SD +/-6.6 against mean of 9.6 years SD +/-3.0 with in group A with p-value 0.000). The mean number of children born to women in group B was 4.1 (+/- 2.4 S.D) whereas it was 3.7 (+/- 1.9 S.D) for the women in group A. There was substantial difference in the two groups of women whether they had ever heard of FP (89% in group A and 45% in group B). In both the groups most common source of information for knowledge of FP were health care workers. Consequently, around 54% of women in group A were currently using any FP method as compared to 25% women currently using any FP method in group B. One of the most common reasons cited by women in group B for not using FP was lack of knowledge about FP as well as lack of access to FP services.

Variables showing significant relationship with current use of FP at bi-variate level are educational status of women, their employment status, present age, family type (Nuclear or extended), husband’s income and belief whether FP is against Islamic teachings. All relationships were significant (p-value 0.000). Apparently women in group A are provided the correct information about Islamic teachings regarding family planning as about 90 % women from group A (health coverage group) believe that family planning was not against Islam whereas, only 45% women from non-health coverage group believe so. Results of logistics regression analysis suggest that women who had health coverage, after adjusting for their socioeconomic and demographic characteristics were significantly more likely to use FP methods.

5. Research: State knowledge contribution

In conclusion, the findings our study reveals, that women receiving health coverage were significantly more likely to use FP methods. Despite living in Karachi for a shorter period, their usage of FP was quite higher almost comparable to that of local Karachi population. As health care workers were most frequent providers of knowledge in regard to FP, women receiving health coverage had far better knowledge and usage of FP. We therefore recommend that refugee population should be given proper health care coverage in order to increase the use of family planning methods with the aim of decreasing their fertility.

P1: 6

Outreach Model Assessment

James, Oniza Geria, Fred, Kintu Mubiru, Dr Justine Coulson

Maristepes Uganda, Uganda; geria2006@yahoo.co.uk

1. Background/Significance

Marie Stopes Uganda (MSU) is a non-governmental organization focusing on family planning and reproductive health for both men and women of reproductive age. With support from DFID, EC, RAISE and the Choice fund from Marie Stopes International-UK. MSU has been providing compassionate, free services that are accessible to local communities through the outreach model for more than 10 years. Currently, it operates 17 outreach teams that move out from the MSU static centres to perform procedures to clients who are mobilized and referred to the rural, usually government health facilities by Community Health Workers. Depending on the number of clients mobilized in an area, the team may plan to camp in an area for a few days. The overall objective is to enable poor and underserved communities to access quality, affordable and appropriate family planning services.

2. Research:
The outreach model seems to be fully portable for the provision of a much needed service of long acting and permanent family planning methods and has been used for a long period of time. However, no evaluation had been done to assess the effectiveness of the model in increasing access to quality FP, mobilization, and Information Education and Communication (IEC) strategies. It was therefore, imperative that a study be done to evaluate the effectiveness of the outreach model being used in order to identify constraints and opportunities from the model used that can inform future efforts to further improve provision family planning services to rural poor and disadvantaged communities. In response to the above study questions, the Cohen Fund through MSU-UK funded an assessment for the MSU’s outreach model which was done in May, 2008.

3. Methodology
The study was conducted in the five regions of Uganda where MSU outreaches are operational. It utilized both quantitative and qualitative methods of data collection such as; exit interviews, key informant interviews and focus group discussions. Purposive sampling was used to select the study sites. This was based on existence of MSU outreach services in an area and performance of sites. Univariate and Bivariate analysis was used for analyzing the quantitative data. Analysis of the focus group discussion and key informant data was done using thematic and content analysis approach.

5. Findings
It was established in this study that the youth especially between the ages of 15-24, were not benefiting from the services equitably. Only 18.2% benefitted from the services during the period of the study compared to 40.9% between the ages of 25-34. Comprehensive knowledge of female clients on tubal ligation, IUD and implants was noticeably low at 30.3% despite the sensitization efforts of CHWs and counseling by the providers. Myths and misconceptions about the LTPMs in the communities still existed. For instance, Vasectomy was reported by some participants in focus group discussions as being equal to castration and loss of manhood, while others reported that due to tubal Ligation and implants affect women’s health negatively. There was high uptake of IUD and Vasectomy in the Western region compared to other regions. Although CHWs were the major source of information for the FP services, it was found out that local councils play a big role in the promotion of other health initiatives in the communities. Overall, the model provides quality services to the clients; however, clients still take longer hours in getting services due to the distance that the outreach teams have to travel, hence the need for more camping of the service providers in the communities which is costly to the organisation. The referral system through using CHWs was found to be effective. 69.8% of the clients had been sensitised and referred either by community or health unit based CHWs.

6. Knowledge contribution
The findings from the study were discussed in a dissemination event that reviewed the recommendations and decided on actions towards improving the outreach service model. These included the following:
- The model needed to package some services specifically for the younger people.
- There would be need to develop the counseling skills especially, choice counseling among the CHWs and service providers through refresher trainings.
- A more effective and better mobilization strategy would need to be developed and bring on board use of local councils and satisfied users.
- Efforts would be made to ensure that Outreach protocol for service provision is adhered to.
- Funding would be sought to enable the need for longer periods of camping during the outreaches.
- There was need to conduct a study to better understand why there is high uptake of IUDs and vasectomy in the Western region hence finding out the opportunities for, and barriers to use of IUD and vasectomy in other regions.

P1: Integration of family planning with health facility and community-based services: Multi-country data on the extent of Lactational Amenorrhea Method (LAM) counseling and the transition from LAM to other modern contraceptive methods

Justine Avinash Kavle, Irit Sinai, Sujata Bijou, Victoria Jennings
Georgetown University, Institute of Reproductive Health and School of Medicine, Department of OB/GYN; jdk88@georgetown.edu

Background/Significance: Poor birth spacing contributes to a significant proportion of maternal, neonatal and child mortality and morbidity. Further, two-thirds of women states they would like to use a family planning method within the first year postpartum. Routine maternal and neonatal health contacts present opportunities to provide messages on postpartum family planning, birth spacing and maternal and child health to women. Lactational Amenorrhea Method (LAM) provides an effective and sustainable way to space/limit births and support optimal breastfeeding and child survival practices in the initial 6 months postpartum. Further, LAM counseling provides an opportunity for women to hear messages about the transition to another method of family planning. Yet, although LAM is a viable and sustainable postpartum contraceptive method used knowingly or unknowingly by many breastfeeding women, family planning (FP) providers are often poorly equipped to offer LAM. A few studies in which health providers gave family planning information during antenatal care showed mixed findings - from no differences in contraceptive use to a positive relationship between past antenatal care and subsequent contraceptive use, or a greater likelihood that women utilize postpartum care services. More programmatic evidence is needed on the transition from LAM to other contraceptive methods, particularly in rural, low-resource settings. Further, evidence is needed on the provision of LAM, messages on postpartum family planning during routine health contacts, and whether women transition to other family planning methods within facility-based and community based services. Methodology Intervention/Activity Tested: The Institute for Reproductive Health (IRH), Georgetown University is evaluating LAM within the context of access and availability of family planning services, by examining the process and impact of scale-up of LAM into family planning programs in Mali, India and Rwanda in January-August 2009. Methodology: The objective of this multi-country study will be to provide a baseline measure of the extent of LAM counseling at maternal-child health and family planning visits, LAM knowledge, attitudes and practice (KAP), and the use of postpartum family planning, within the context of the transition of LAM to another family planning method in IRH project areas. Descriptive analyses from women of reproductive age will be presented from India and Mali. These data will give information on infant feeding practices and messages on LAM given during antenatal and postnatal care, knowledge and opinion of LAM, as well as postpartum family planning use, method of choice, and the transition from LAM to other modern methods of family planning. Health facility, family planning provider and community health worker interview data from Mali and Rwanda will provide information on messages, training of health providers and the extent of counseling and messages given on LAM. Findings: We present multi-country survey data to assess the level of integration of LAM in health service provision, prevalence of method use, provider attitudes, and knowledge. Forthcoming analyses will compare and contrast household level, facility and community level data between countries. Knowledge contribution: These multi-country data will provide evidence on the transition from LAM to other contraceptive methods, as well as the provision of LAM, and messages on postpartum family planning during routine health contacts.
Knowledge of Some Ghanaian Service Providers on the Reproductive Rights and Reproductive Options Available to HIV-Positive Ghanaian Women

Amos Kankponang Laar
School of Public Health, University of Ghana, Legon, Ghana; a klaar@yahoo.com

Background/Significance

Recent advancement in HIV therapy and improved treatment of its associated opportunistic infections has significantly increased the quality of life HIV-positive adults. As a result, a number of HIV-positive persons of reproductive age are likely to consider becoming parents. Unfortunately, reproductive rights or parenting options available to persons living with HIV have hardly been addressed in Ghana. Since the year 2001 when voluntary counseling and testing (VCT) and prevention of mother-to-child transmission of HIV (PMTCT) services were initiated in Ghana, little research has been done to appraise the knowledge of the service providers particularly on the above issues. This study explored the knowledge of service providers in Ghana about the reproductive rights and parenting options for HIV-positive women who want to conceive.

Main question/Hypothesis

What is the level of knowledge of VCT providers, and other PMTCT counselors on;
(i) the reproductive rights of Ghanaian women living with HIV?
(ii) the reproductive options available to Ghanaian women living with HIV?

Methods

The study was facility-based cross-sectional in design involving the entire population of 35 VCT counselors/other PMTCT service providers at the Tema General Hospital (Tema, Accra), the Atua Government Hospital, and the St Martins Hospital (both in the Manya Krobo District). Knowledge of these providers on the reproductive matters of HIV-positive Ghanaian women was assessed through structured interviews after informed consent. Additionally, in-depth interviews were done involving three of the counselors in charge of the PMTCT programs at the three hospitals. Statistical analysis was done using SPSS Version 15.0. Associations between certain demographic attributes of the providers and their behavior/level of knowledge were tested using Chi Square test, and logistic regression analysis. The data from the in-depth interviews were analyzed manually. This consisted of appraising the jotted notes, and synthesizing them into meaningful themes.

Findings

The findings give two main revelations regarding the knowledge of the service providers on the reproductive matters of women infected with HIV. There was an overwhelmingly high level of approbation by the providers on HIV-positive women’s right to reproduction (94.3%). A considerable proportion of the providers (57.1%) also asserted that women infected with HIV in their settings have the same rights as their uninfected counterparts to contraception. At the same time, they providers demonstrated a disappointingly high level of ignorance regarding the various reproductive options available to women infected with HIV in Ghana. Only eight of the 35 providers (22.9%) were aware that measures exist in Ghana to help HIV-positive women conceive and reproduce safely. 4 (11.4%) were aware of reproductive options for HIV-positive women, and only 9 (25.7%) would advise HIV-positive woman to have an unproductive intercourse as an option to have children. Significantly higher proportion of 2 (1) = 8.11; p = 0.004), and those providers from the Manya study site (2 (1) = 4.47; p = 0.035), found it inappropriate to younger than 30 years (provide contraception to HIV-positive children. Compared to their counterparts from the Manya study site, providers from the Tema site were more likely to prescribe to their clients unprotected intercourse as a reproductive option OR = 2.56; 95% CI (1.11 – 5.85). So were providers with tertiary level education OR = 1.86; 95% CI (1.14 – 3.02). However, in a multiple logistic regression analysis that controlled for religion, education, and gender of the provider, the above could no more predict the behavior of a provider/level of knowledge. The in-depth interviews revealed that some of they providers found themselves unable to give qualified and relevant advice to HIV-positive women on the various reproductive options.

Contribution to knowledge

These findings light up some of the problems these providers face in their role as counselors. The organization of PMTCT counseling must to a larger extent take into account these realities and incorporate reproductive health issues of HIV-persons into the existing guidelines.

P1.9

Increasing Number of People having Access to Counseling and Non-Prescriptive Methods of Family Planning Commodities in 16 COMPASS LGAs of Kano State, Nigeria.

AbdulHamid Abdullahi Bagara
Community Health and Research Intitative, Nigeria; aabagara@gmail.com

Background

Kano state is the most populous state in Nigeria with over nine million people (NPC 2006 census). The state is located in Northern part of the country with 90% of indigenous inhabitant are Hausa/Fulani with deep rooted traditional and cultural beliefs that limits Public discussions on issues such as reproduction and Family Planning (FP).

According to COMPAS/USAID project base line survey in 2005, the contraceptive prevalence rate was 1% and the total number of FP clients was 19077 in the state. However, the state Government has established FP clinic in the Specialist Hospital in the state capital and 27 General Hospital across the state, but due to low level of accurate information about the FP people were not accessing the services. In the same study few people that decided to use modern contraceptives, didn’t want to go to hospitals but rather consulting the Patent Medicine Vendors (PMVs) in their community due to fear of rejection by the fellow community members. The non prescriptive methods of FP commodities for the purpose of this project were: Condoms and oral pills.

This project was implemented by CHR and covered five month intervention (June 2006 to October 2007) Targeted 16 COMPASS LGAs of Kano state and aimed:

- Identify 126 patent medicine vendors (PMVs) and trained them on FP counseling and non-prescriptive method of FP services to serve as Community Based Distributors (CBDs) in their communities.
- To trained 45 Community Health Promoters (CHPs) on Effective Counseling on FP and serve as community counselors.
- To reached 6000 men and women with counseling and non-prescriptive method of FP commodities by the PMVs and 10000 men and women with FP counseling and information by the CHPs in five month.

Intervention/Activities

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PIC meetings: The committee is meeting weekly to plan next week activities and reviews the project implementation.

Advocacy visits: Advocacy visits were paid to LGAs Authorities and PMVs association of the LGAs.

Selection of PMVs and CHPs: 126 PMVs were selected to participate in the training. The number of representative by LGAs depended on whether the LGAs was urban or rural LGA.

Capacity building training: The PMVs were trained for three days in 4 cycles and the 45 CHPs were trained for three days. The training adopted paper presentation, Facilitation Role play and Group work. The topics covered were:
- Basic Anatomy and Physiology of Reproductive system
- Introduction to child spacing
- Interpersonal communication
- Effective Counseling Techniques
- Various Method of FP
- Referral system
- Record keeping and Documentation

Methodology

The Trained PMVs and CHPs were given referral forms for people that wanted prescriptive methods of FP and data collection forms for documenting the people reached with commodities and those reached with counseling and information. The CBDs were also linked with LGAs primary Health care departments and markets for the supply of commodities.

The CBDs and counselors were monitored and data about the number of people reached with counseling and FP commodities were collected from both CBDs and Counselors as well as challenges encountered by them and address them together with the project team.

Findings

At the end of the project, 126 PMVs were trained on FP counseling and providing and distributing non-prescriptive method of FP. 45 CHPs were trained on FP counseling and information shearing and sensitization on FP. 10,874 (3815 Males, 7059 Females) where reached with FP counseling against 10,000 people targeted. 6944 (2793 Males, 4151 Females) were reached with non-prescriptive method of FP commodities. In general it showed that most of the people in the state preferred accessing the FP commodities in secret from the local PMVs then going to hospitals, because hospitals were public places. Also 11 women were referred to hospitals for their desire to use prescriptive methods.

Lessons Learned

People in Kano state Northern Nigeria wants to use FP to achieve their reproductive desire, but they are been challenge by their cultural beliefs and community influence. Therefore going to FP clinic in the hospitals due to the fear of people seeing them there, and subsequent rejection, they prefer accessing the FP information and commodities within their vicinity espitally, from the PMVs they know for long time and blief. they will not be harm to them. Therefore, projects like this, should be scale up to help people in this part of the world to achieved their FP needs by making use of the local people to access both information and commodities on FP from their local community. This would help in changing their behaviour, perception and ease access to its services.

P1: 10

Identifying different stages in community mobilization for Family Planning use

Feven Tassew, Seifu Tadesse, Frehywot Eshetu, Barbara Pose

CARE International, SRH Programme, Ethiopia; FevenT@care.org.et

Sub.Title: - the need to monitor closely the changes on the demand and the supply side over time-

Background/Significance

CARE International in Ethiopia is implementing Family Planning (FP) Programs using an extensive Community mobilization approach in Oromiya Region since 1996 with significant success in addressing unmet need.

The program had three phases targeting three neighboring geographic areas and addressed over three periods of 6, 4 and 3 ½ years respectively, in addition to FP, topics such as awareness raising for HIV/AIDS and women empowerment.

Hypothesis or Intervention/Activity Tested

The uptake of FP through community mobilization in neighbor communities is not a uniform process. The knowledge of different stages is important to facilitate relevant planning for commodity supplies and capacity building.

Methodology

The Sexual Reproductive Health Coordination Unit of CARE Ethiopia reviewed the Baseline Surveys from 1996, 2003 and 2006 and compared them with the respective Final Evaluations from 2001, 2005 and 2009. Similarities and differences in the mobilization process were identified and the team analyzed the process and identified the different steps over time and geographic location.

Data

The data shows trends for the three phases. To interpret the figures one has to take into account that the three phases don’t build on each other as the implementation area was different. Hence every project must be regarded for itself.

Phase1 (1995-2001): In the first phase knowledge on-- family planning (two methods) rose from 48% to 73%. The current contraceptive use of FP by women of reproductive age rose from 4% to 24.7 and use of long-term contraceptives rose increased from 0 to 0.74%. Among women who wanted to have (another) child, 78(52%) non-contraceptive users answered that they would want to have a baby after 2 years indicating high level of unmet need for family planning

In Phase 2 (2001-2005) the set-off point for— Contraceptive Prevalence Rates (CPR) was already significantly higher, CPR increased from 14.7% to 29.8.

Knowledge increased from 90 to 99%. Injectable and implants became the two predominant methods uses by 45.1% and 30.6% of the contraceptive users respectively.
In Phase 3 (2006-2009) CPR increased from 15.5% to 27.7%. Long-term contraceptive methods in form of Norplant continue to be on highest demand in most project sites. However in pastoralist settlements condoms are the preferred choice with 85%.

IUCD, vasectomy and tubal ligation are rarely used and— demanded and misconceptions on these methods are frequent in the population.

Although CPY has increased considerably in CARE’s— implementation areas over the last 13 years the Phase 3 data shows that however 42.1% of women reported that their last pregnancy was mistimed.

Findings

The first step of a family planning program in an ignorant community must focus on knowledge increase and overcoming barriers i.e. due to religious beliefs. At this stage short term contraceptives are the first choice of community members to get started and experience FP. Over the time when awareness increases the method mix requested increases and middle and long-term methods dominate the demand side. In this phase policies and health systems need attention. Application of implants needs skilled providers and performing commodity supply systems. The health policy in Ethiopia is giving injectables in the hands of health services providers. Positive experiences with volunteers giving Depot Vera shots in other African Countries haven’t yet had an impact on the health policy.

Shift of consumer preference from short-term (pills and condoms) to medium and long-term FP devices needs to shift focus on the supply side of FP devices. Capacity building of health service providers and quality of service improvements become important. In Ethiopia Intra Uterine Devices (IUDs) are not very common due to lack of skilled providers plus several misconceptions which haven’t yet been addressed by campaigns to be overcome. Different lifestyles – i.e. pastoralist – can lead to deviations from expected behavior.

Despite all successes – end of phase 1 and phase 3 (last pregnancy mistimed) show that despite all CARE efforts an unmet need for FP persists in implementation areas which needs further exploration.

Knowledge Contribution or Lessons Learned

Mobilization for FP is not a straight forward process:

1. FP programs need to plan for different sets of activities depending on the set-off point of knowledge on FP and demand for contraceptives existing in a population at project inception.

2. FP is a political and a policy issue. A FP project should conduct a harm-benefit analysis at inception stage to identify the different stakeholders and players, the barriers and enabling factors, to determine the implementation activities.

3. Planning a FP program should include reflections on changes over time. Different scenarios need different responses.

4. A program must plan beyond community mobilization for demand increase but must take into consideration the health system’s weaknesses and strengths: the capacity of the providers i.e. to provide mid-term or long-term contraception and the logistical capacity of the system to shift between methods and respond to increased demand.

P1: 11

Contraceptive use and its determinants in Central India: A comparative study of tribal and non-tribal population

Ravendra Kumar Sharma¹, Manju Rani²

¹Regional Medical Research Centre for Tribals (ICMR), India; ²Government Degree College, Chhaprauli, Baghapat (Uttar Pradesh), India; ravendra_s@yahoo.com

Background:

Central India (Madhya Pradesh & Chhattisgarh states) is one of the most populous regions of India and about 23 percent of its population is tribal (Census 2001). The region is also an economically and demographically backward - the utilization of RCH services is very poor in this region- particularly among tribal communities.

Data & Methodology:

Recently conducted District Level Health Survey (DLHS-RCH II) data is used to explore the pattern of contraceptive use, and prevalence of contraceptive morbidities among tribal women of central India. Both bi-variate and multivariate (binary logistic regression) techniques are used to comprehend the determinants of contraceptive use in central India.

Findings:

The knowledge of family planning method is almost universal and most of the tribal and non-tribal women are aware of at least one modern method. Out of 42 percent current users of family planning methods, 32.7 percent are using female sterilization and 1.8 percent male sterilization. The most commonly used method is female sterilization, which is adopted by 32.7 percent currently married and non-pregnant tribal women. Female sterilization alone accounts for 78 percent of current use of contraception.

Tribal couples adopt female sterilization mainly after completing their desired family size, i.e. having two or more surviving sons. Although Government has banned sterilization among primitive tribes in 1979, but higher acceptance of sterilization may reflects poor quality and efficiency of family planning programme. Tribal couples may be just accepting sterilization for the sake of monetary benefits, and most of them adopting after achieving desired family size and in older ages (aged 35 and above). It is also supported from the evidence that more than 90 percent tribal women undergone sterilization at Government Hospital/PHCs or Sub-centres. Less than one-fourth of them were informed about possible side effect of sterilization and less than half received any post-sterilization follow up visits. It is also observed that 17–20 percent women had experienced at least one side effect of female sterilization. This again reflects a panic situation of Government Family Welfare Programme. Multivariate results also show that use of sterilization increases with age of women, marital duration, number of children and number of sons surviving.

Lessson Learned & Conclusion:

Thus to increase use of contraception, especially in peak reproductive age groups, family planning programme needs to promote the temporary methods – including Pills, IUD and condoms and improvement in the quality of family planning services is essential in tribal areas.

P1: 12

Unmet Need for Contraception in India : Trends and Differentials

Ulimiri Venkata Somayajulu
The National Population Policy, 2000 of the Government of India set a goal of achieving replacement level fertility of 2.1 children per woman nationally by 2010. This goal seems unrealised as the National Family Health Survey (NFHS)-3 indicates that at current fertility rates, India's women will have an average of 2.7 children per woman, slightly lower than 2.9 children per woman measured in 1998-99 by NFHS-2, but above the replacement level. The National Population Policy states that population stabilisation is a priority area for states addressing the unmet need for contraception in view of the concern due to large unmet need for contraception. Unmet need for contraception is an important indicator of potential demand for contraception assessment.

Objectives

The present paper aims at examining the levels and trends of unmet need for contraception in India at national as well as state levels and also understanding the differentials of unmet need. The paper also provides a brief status in terms of awareness and extent of use of contraception and suggests policy as well as programme implications so that the young women can be saved from the unwanted burden of child bearing as they are more at risk.

Data and Methodology

The paper uses the NFHS-2 and 3 data carried out during 1998-99 and 2005-06. Besides univariate analysis; multiple regression analysis is used to find out the determinants of unmet need.

Findings

Knowledge of at least one method of modern contraception is universal as 97 percent of women and 95 percent of men of 15-49 years heard of female sterilisation, but other methods are less popular. More than half of currently married women at national level (56%) reported use of some method of contraception, with almost half (49%) being users of modern method of contraception. Female sterilisation accounts for more than third fourth (77%) of all modern method use.

Currently married women who are not using any contraception method but do not want any more children are considered as having unmet need for limiting. The currently married women who are not using contraception but want to wait two or more years before having another child are considered as having unmet need for spacing. Table 1 gives the trends in unmet need on the basis of NFHS 2 and 3.

Table 1 Unmet Need for Spacing and Terminal Methods

<table>
<thead>
<tr>
<th>NFHS 2(%)</th>
<th>NFHS 3(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>15.8</td>
<td>12.8</td>
</tr>
<tr>
<td>Terminal methods</td>
<td>7.5 6.6</td>
</tr>
<tr>
<td>Spacing methods</td>
<td>8.3 6.2</td>
</tr>
</tbody>
</table>

Younger women (15-24 years) have the highest unmet need for contraception (27 %) and higher unmet need for spacing than for limiting – 25% vs 2%. Rural women have higher unmet need for spacing as well as limiting. The unmet need for spacing increases with woman’s education but women with no education recorded the highest unmet need for limiting. As regards the religious differentials, Muslim women recorded higher unmet need.

During NFHS 2 and NFHS 3, unmet need for contraception decreased by about 3 percentage points. Decrease in unmet need for spacing is higher than that for limiting during the inter survey period. Analysis by state indicates wide ranging differentials in unmet need – 5% in Andhra Pradesh to 35% in Meghalaya. In Nagaland, Jharkhand, Bihar and UP, more than 20% of women have unmet need for contraception.

Knowledge Contributions/Implications

The analysis indicates the need for creating enabling environment by ensuring availability of quality FP and RCH services, meeting the felt needs of couples and helping the couples in achieving their reproductive health goals.

The family planning programme, World’s first official national FP programme, needs to be strengthened by initiating following steps:

- Assured delivery of FP services, particularly in rural areas
- Developing skilled human resources
- Increasing male participation
- Enhancing quality of services/care
- Increasing basket of choices for the couples
- Strengthening social marketing /social franchise
- Addressing the needs of young women with low levels of education and poor economic status

P1: 13

**Market Segmentation to Reduce Inequity in Access and Use of Family Planning in Latin America and the Caribbean**

_Dana Aronovich, Nora Quesada, Disha Ali, Carolina Arauz, Juan Agudelo, Sonia Anderson_

USAID | DELIVER PROJECT, United States of America; daronovich@jsi.com

1. Background/Significance

Stakeholders in Latin America and the Caribbean have made tremendous progress in promoting contraceptive security (CS) efforts at the national and regional levels. In many countries in the region, family planning (FP) programs have successfully reached clients and provided high-quality services and a broad range of methods. The total contraceptive prevalence rate (CPR) among married women of reproductive age for the region is 71 percent, with most (64 percent) using a modern method (www.prb.org ). Now, policy makers, program managers, and other stakeholders are focusing on reducing inequities in access to and the use of FP between the wealthiest and the poorest segments of these populations. Many of the countries have both effective public sector FP programs, as well as a thriving private sector. Yet, these resources are not always allocated efficiently and effectively to meet all clients’ needs or to address outstanding unmet need that still exists, particularly among poor and rural sub-populations.

2. Hypothesis/Main questions
A market segmentation analysis (MSA) is one of the tools that can be used to promote CS by developing a better understanding of the contraceptive market in a country and where resources are being allocated, and by identifying problems of access and equity between socioeconomic groups. Using this analysis, countries can develop plans to meet current and future needs of the population, to improve equity between segments of the population, and to better target their resources to meet these goals.

Recent MSAs have been completed in the Dominican Republic (DR), Honduras, and Nicaragua. The research looked at the factors that affect equity of access to and use of family planning — clients’ level of education, age, location (urban/rural, region/district), method choice, unmet need, source of supply, and socioeconomic quintile, as well as trends over time.

3. Methodology

The research involved a secondary analysis of data from the most recent DHS or RHS. To study these variables and trends in the DR, data from the 2002 and 2007 surveys were analyzed; in Honduras, data from the 2001 and 2005–06 surveys were used; and in Nicaragua, data from the 1998, 2001, and 2006–07 surveys were analyzed.

The distribution of key variables was studied independently, as well as by socioeconomic groups, then cross-tabulated with other variables to explore the relationship between product use and relevant variables.

4. Data/Findings

The MSAs conducted for these countries all show that efforts to expand access to and the use of FP have been successful. However, there are still discrepancies between socioeconomic quintiles that need to be addressed in total fertility rates (TFR), contraceptive use, unmet need, and source of contraceptive supply. In all three countries, TFR has declined significantly over the past decade and CPR has been steadily rising. However, when reviewing these variables by quintile, TFR is more than twice as high in the poorest quintile than in the wealthiest. Similarly, CPR is significantly higher among wealthy women than poor. For example, CPR in Nicaragua is 79 percent among the wealthiest women but only 65 percent among the poorest. In addition, wealthier women in all three countries use female sterilization at a much higher rate than poorer women, who tend to use injectables as their preferred method. This may result from the high upfront cost of sterilization or it may reflect disparity in access to FP, because sterilization requires a clinic setting and highly trained staff, but injectables can be offered at lower levels of the health care system.

While unmet need is declining in all three countries, discrepancies between socioeconomic groups remain. In Honduras, unmet need was only 11.2 percent for all women in 2005–06, but it was more than twice that (24.2 percent) among women in the poorest quintile. Rural women, in general, also register higher unmet need and lower CPR than urban women; poor women constitute the majority of rural populations.

When analyzing sources of contraceptives by quintile in the three countries, it is clear that the public sector serves a much larger percentage of the lower quintiles, while the private sector serves a larger percentage of the wealthiest clients. This could reflect ability to pay for FP—wealthier clients can afford to pay for private sector services, but poorer clients are more dependent on the public sector. It could also reflect access to FP because the poorest groups (concentrated in rural areas) have fewer private-sector options than the wealthiest (mainly urban residents), who have more private-sector options.

5. Knowledge contribution/lessons learned

From these analyses, it is clear that some discrepancy in equity of access to FP between socioeconomic quintiles remains and that the poorer groups’ needs are not being completely met by existing services. To continue to move toward contraceptive security in these countries, partners working in reproductive health must make a greater effort to expand access to information, services, and commodities for FP to all segments of the population.

P1: 14

Unmet need for family planning in India: factors affecting and actions required

Manas Ranjan Pradhan1, Hiralal Nayak2

1MAMTA Health Institute for Mother and Child, New Delhi, India; 2International Centre for Research on Women, New Delhi, India; manasranjanpradhan@rediffmail.com

Background/Significance:

Unmet need for family planning is an important indicator for assessing the potential demand for family planning services. The National Population Policy of India (2000) advocates for addressing unmet need for contraception to achieve the medium-range objective of bringing the total fertility rate down to replacement level by 2010.

Hypothesis or Intervention/Activity Tested:

The present study focuses on factors associated with the unmet need for family planning.

Methodology and Data:

Data from the National Family Health Survey-III (2005-06) covering nationally representative sample of 93089 currently married women aged 15-49 years have been analyzed for the present analysis. The data has been analyzed through SPSS 15.0 and the analytical approach includes both bivariate and multivariate analysis. Multivariate analyses have been performed to identify the factors associated with unmet need for family planning. Geographical Information System (GIS) has been used to show the potential heterogeneity in the data.

Findings:

The study reveals that 13 percent of currently married women in India have an unmet need for family planning. The unmet need for limiting (7 percent) is slightly higher than the unmet need for spacing (6 percent). Unmet need decreases with age, from 27 percent for women age 15-19 to 2 percent for women age 45-49. Younger women (age 15-24) have a greater unmet need for spacing than for limiting. For older women, the reverse pattern is evident. The unmet need for spacing decreases very sharply from age 15-19 to age 35-39, beyond which it is negligible. The unmet need for limiting increases through age 25-29 and then decreases continuously. Rural women have a higher unmet need than urban women for spacing as well as limiting. The unmet need for spacing increases with increasing education but the unmet need for limiting is highest for women with no education. Unmet need for family planning is particularly high for Muslim women and particularly low for Sikh and Jain women. Unmet need for both spacing and limiting decreases with an increase in wealth quintiles. Again, unmet need for family planning varies greatly by state, from 5 percent in Andhra Pradesh to 35 percent in Meghalaya. In addition to Meghalaya, more than 20 percent of women have an unmet need for contraception in Nagaland, Jharkhand, Bihar, and Uttar Pradesh. Unmet need for spacing ranges from 3 percent or less in Himachal Pradesh, Punjab, and Andhra Pradesh to 10 percent or more in Meghalaya, Mizoram, Jharkhand, Bihar, and Nagaland. Unmet need for limiting ranges from 2 percent in Andhra Pradesh to 16 percent in Nagaland. Similar to the national pattern, in most states the unmet need for limiting is higher than that for spacing.
Logistic regression reveals that age of the woman, education of the woman, number of surviving children, sex composition of the surviving children, religion of the household, wealth quintile of the household and place of residence of the household as significant predictors of unmet need in India.

Knowledge Contribution or Lessons Learned:
Despite the provision of providing the family welfare services at every doorstep, a considerable percent of women are still unable to meet their contraceptive requirements. It may be due to their poor knowledge and the tie-up with the deep rooted gender norms of the society. Again it reflects the gap between the service availability and its utilization. It may be suggested that the family welfare program should target the young population and inform them about the availability as well as usage of family planning services, which would work for reducing the magnitude of unmet need. Additionally, as education has come out as an important determinant of unmet need, girls’ education needs to get utmost attention in family welfare programs.

P1: 15

Comparing Factors Behind the Unmet Need for Limiting and Spacing Births in Sub-Saharan Africa
Keriu Schulters, Issakha Diallo, Diana Silimperi, Jennifer Lizow
Management Sciences for Health, United States of America; idiallo@msh.org

1. Background:
The health, social, demographic and economic benefits of family planning (FP) have been largely studied and used to engage decision makers at various levels. Recent cost benefit analysis of the contribution of FP in achieving the Millennium Development Goals (MDGs) demonstrates that after satisfying the unmet need for FP, as measured by saving when achieving the MDGs, the benefits ranked from US$200-247 million in each of the 16 sub-Saharan countries covered, ranging from US$2.03 for every dollar spent in Ethiopia to US$6.22 in Senegal. Yet the unmet need for FP in sub-Saharan Africa (SSA), estimated at an average of 24 percent, is still to high. Numerous studies reveal that a range of obstacles other than lack of physical access to services prevents women from using FP. This study was conducted to contribute to the research on factors most likely associated with this unmet need for FP in SSA, either for spacing or limiting births.

2. Research Question:
This study aims to determine and compare the likely underlying causes statistically associated with each of the types of unmet need - for spacing and for limiting - and the total unmet need for FP in SSA.

3. Methodology:
This study uses bivariable analysis to examine quantitative data from countries' most recent Demographic and Health Surveys (DHS). Analysis was conducted on 29 SSA countries with a DHS survey between years 2000 and 2007. These countries include: Benin, Burkina Faso, Cameroon, Chad, Congo, D.R. Congo, Eritrea, Ethiopia, Gabon, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe. Overall, 28 independent variables were examined, including economic, health, social, and demographic indicators. Dependent variables included the total unmet need, unmet need for spacing, and the unmet need for limiting. Variables were analyzed using Pearson’s and Spearman’s correlation analysis.

4. Data:
The results from the bivariable analysis showed that seven of the 28 independent variables are correlated to the unmet need for spacing, six are correlated to the unmet need for limiting, and only one was found to be correlated to the total unmet need. Variables determined to be significantly associated with the unmet need for spacing include: GINI coefficient (r = 0.517; p = 0.012); percent of women who are literate (r = 0.473; p = 0.015); percent of women with no education (r = 0.372; p = 0.047); fertility rate (r = 0.416; p = 0.025); percent of married women who reported having a problem accessing health care (r = 0.478; p = 0.018); percent of women who have ever used any contraception method (both modern or traditional) (r = 0.580; p = 0.001); and median number of antenatal care visits for live births in the three years preceding the survey (r = 0.486; p = 0.008).

In contrast, for the unmet need for limiting, the following variables were found to be significantly associated: maternal mortality rate (r = 0.398; p = 0.032); wanted fertility rate (r = 0.566; p = 0.001); median age at first marriage (r = 0.424; p = 0.031); percent of married women who know at least one contraceptive method (modern or traditional) (r = 0.459; p = 0.012); percent of women who state their spouse approves the use of FP (r = 0.527; p = 0.025); and the percent of women who have heard FP messages on the radio in the last few months prior to interview (r = 0.453; p = 0.015). Population density was the only variable determined to be significantly associated with the total unmet need (r = 0.411; p = 0.030).

5. Findings:
The results indicate that high levels of unmet need for spacing are correlated to higher levels of literacy, fertility rates, and problems accessing health care and lower levels of formal education, antenatal care use, and ever-use of contraception. For the unmet need for limiting, high levels are correlated to lower wanted fertility rates, older age at first marriage, and higher levels of contraceptive knowledge, spousal approval of FP, and hearing FP messages on the radio. For total unmet need, a higher population density is correlated to higher levels of unmet need.

No variable was determined to be correlated to both the unmet need for spacing and the unmet need for limiting. The main findings from this study suggest more research needs to be conducted on the type of unmet need (i.e., for spacing and limiting) at the regional or national level, rather than examining the total levels of unmet need across SSA.

6. Knowledge Contribution:
Overall, the analysis showed the major factors behind the unmet need for spacing and the unmet need for limiting, and it also revealed that they are very different, suggesting our interventions to meet the unmet need should be tailored to address these differences.

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Increasing Access to Family Planning Services Among Indigenous Groups
Elizabeth Mallas1, Lucia Merino1, Marisela De La Cruz2, Alejandro Silva3, Gustavo Gutierrez3, Vilma Morales de Oquendo2, Carlos Bauer4, Edwin Morales5, Sara Netzer6
1 Futures Group International/USAID | Health Policy Initiative, Task Order 1, United States of America; 2 Ministry of Health, Guatemala; 3 Guatemalan Social Security Institute, Guatemala; 4 Guatemalan Family Planning Association, Guatemala; 5 Futures Group International/USAID | Health Policy Initiative, Task Order 1, Guatemala; 6 The Centre for Development and Population Activities/USAID | Health Policy Initiative, Task Order 1, United States of America; emallas@futuresgroup.com

Background/Significance
Indigenous populations make up 40% of the total population of Guatemala. There are 21 ethno-linguistic groups. Four (the K’iche’, Q’eqchi’, Mam, and Kaqchikel) account for 81% of the total Mayan population.

Access to healthcare services, especially family planning (FP) services, is inequitable and does not meet the needs of indigenous peoples, the majority of whom are poor inhabitants of rural areas. As a result of these inequities, the country’s overall maternal mortality rate is 153 deaths per 100,000 live births. For indigenous women, the rate is 211 per 100,000 live births.

The institutions that provide FP and reproductive health (RH) services need information on specific needs of the indigenous population in order to develop strategies that respond to these needs and improve the health situation of this population.

Hypothesis or Intervention/Activity Tested

In Guatemala, the Ministry of Health (MSPAS), the Guatemalan Social Security Institute (IGSS), and Guatemalan Family Planning Association (APROFAM) have made significant efforts to expand access to FP services for women and men, enabling more people to satisfy RH needs. The 2002 National Survey on Maternal and Child Health found that these services are still not within reach of many poor inhabitants, primarily those living in rural, indigenous areas. It found that unmet need for FP was 27.5%. The rate for rural women was 32.3% and jumped to 39.3% for indigenous women.

To focus efforts to expand access and ensure equity in the provision of FP services, it was necessary to ask: Does the MSPAS provide FP services to the country’s poorest populations? Do the poor, mostly indigenous, from rural areas, find FP services that understand and meet their needs?

To gather information to find the answers, a study was conducted in three departments (provinces) with a high percentage of indigenous populations (over 90%) and high rates of maternal mortality. Key objectives included:

(1) Exploring the perception of indigenous women, users and non-users of contraception, regarding FP and the quality of care received from healthcare providers.

(2) Identify the perceptions and biases held by FP service providers that become a barrier to high-quality healthcare for indigenous populations.

Methodology

The study was carried out in three departments (Sololá, Totonicapán, and Quiché) between August of 2006 and February of 2007. Data collection included:

Desk review of existing data on the life conditions of indigenous populations and access to healthcare services.

Individual structured interviews with 108 providers from MSPAS, IGSS, and APROFAM in Sololá (29%), Totonicapán (24%), and in Quiché (47%). Interviewees included doctors (27%), professional nurses (20%), nurse assistants (36%), and FP staff (17%).

33 group interviews with 168 indigenous women including users (36%) and non-users (64%) of contraception; and 69 community educators and traditional midwives.

Excel and Epi Info were used to process the information collected and to analyze the results by department and institution. Results were discussed and analyzed extensively with the organizations participating in the study and validated with different technical groups.

Findings

Various barriers were identified that limit the access of indigenous populations to timely FP information and quality, culturally-sensitive services. Four, originating in health services include: 1. Bias from providers toward indigenous women; 2. Provision of inappropriate conditions for services; 3. Lack of adequate FP informational materials; and 4. Inappropriate conditions for the integration of community staff for FP services. Two related to the community and family environment: 1. Biases and misconceptions about FP effects; and 2. Restrictive social and community environment for the use of FP.

Approximately half of the providers demonstrated bias toward indigenous populations, limiting the quantity and quality of information and services received. About 40% of the establishments included in the study did not have appropriate conditions to provide FP services. Activities do not address clients’ doubts and misconceptions.

Language issues are another key barrier, for face-to-face counseling and in provision of printed materials and instructions. While 60% of providers stated that they offer information and counseling in the regional Mayan language, there is no certainty regarding the accuracy of the translation or how it is perceived by clients.

Knowledge Contribution or Lessons Learned

Barriers that limit access to FP services for indigenous populations should be addressed at different institutional levels by creating policies that support working with indigenous groups; designing operational policies to improve quality and promote culturally-sensitive services; adapting information, education, and training strategies to the reality and needs of indigenous peoples.

In addition, it is recommended that a national inter-institutional strategy be developed that includes: a) ongoing training; b) information strategies to address myths and negative attitudes toward contraception; c) FP services provided by staff who speak the regional Mayan language and/or translators trained for such purpose; d) promotional materials adapted to the information needs of indigenous populations; e) sensitization of community leaders and groups regarding the benefits of FP; and e) strategic alliances to monitor access to and quality of FP/RH services for indigenous populations.

During the study, indigenous women reported that they do not feel they receive high-quality care at healthcare centers, which they believe is a result of their condition as poor, indigenous people.

P1: 17

Levels and Trends in Unmet need among never-married Nigerians: Implications for Maternal Health and Family Planning Programmes

Ambrose Akilno, Alfred Adewuyi

Obafemi Awolowo University, Nigeria; akinloa@oauife.edu.ng

1. Background/Significance

Maternal health had become a major global concern since the 1987 Safe Motherhood Conference in Kenya. A woman is exposed to the risk of maternal morbidity and mortality with every pregnancy, but a lot of women become pregnant at a time when they do not want to (unmet need), apparently because they were not using a method of family planning.

The outcome of unplanned pregnancies in Nigeria often result in disastrous consequences as a lot of them end in induced abortions (often procured through unsafe clandestine channels, because abortion is illegal in Nigeria) especially among unmarried women. And against the background that Nigeria records the
highest number of maternal deaths annually in Africa and that close to a third of these deaths is attributed to abortion. It is arguable that, if unmet need is satisfied, unwanted pregnancies and by extension, exposure to maternal deaths, could have been significantly reduced in the country. A study to assess the impact of family planning and mortality in China actually found that maternal mortality rate was higher among women whose pregnancies were not planned (Ni and Rossignol 1994).

Most studies have focussed on unmet need among married women. However, the family planning needs of the never-married equally deserve attention as unplanned pregnancies among them will almost certainly result in abortion, sometimes with consequences. The objective of this study therefore is to examine the recent trends in unmet need among never-married women using data obtained from a baseline and midline cross-sectional survey conducted in 2005 and 2007 respectively.

2. Research: State main question/hypothesis
Program: State intervention/activity tested

What is the trend and magnitude of unmet need among never-married women in Nigeria? In view of Nigeria’s high level of maternal deaths, how vulnerable have the contraceptive and sexual behaviour of the never-married made them?

3. Methodology (including location, setting, period, analysis approach)

The data for the study is extracted from two large-scale household surveys on reproductive health, child health and primary school education among a representative sample of women aged 15-49, conducted in five Nigerian states across the 51 local government areas targeted by the COMPASS project. Exactly the same enumeration areas were visited over the two periods, though the respondents interviewed were not necessarily the same. Analysis in this paper is limited to only 1090 never-married women (507 from the baseline survey (2005) and 583 from the midline survey (2007)). The DHS model for unmet need among never-married women (Westoff and Bankole, 1995) is used to compute the levels of unmet need. Descriptive statistics is used to compare the levels over the two periods.

4. Findings

It was found that the current contraceptive use among the total population of never-married women had increased from 11% to 28% during the period. The level of unmet need among the study population reduced from about 48% in 2005 to 24% in 2007, nevertheless, the proportion of unmet need due to mistimed/unwanted pregnancies rose from 0.8% to 4.5%. Among those with unmet need, the proportion that had ever used contraception remained almost exactly the same in 2005 and 2007 (89.6% and 89.3% never used, 10.4% and 10.7% had ever used respectively). On the approval of family planning, the proportion of those with unmet need that approved FP rose from a third (33%) to half (51%), the disapproval however increased by 10% to 33% in 2007 while those who were unsure of their stance declined from 44% to 15%. On the intention to use contraception in future, in 2007, 28% planned to use in future (up from 14% in 2005) but those who do not plan to use also increased from 33% to 42% in 2007 while those unsure declined from more than half (53%) to less than a third (31%). On whether they have ever been encouraged to use FP, only about 35% said yes in both periods. (Further tabulation is in progress, especially cross-tabulations linking unmet need with social and demographic variables, also on unmet need for “appropriate” contraception – never-married, sexually active with multiple partners, but were not using condoms, etc).

5. Research: State knowledge contribution
Program: State lessons learned

The results show that a reasonable proportion of youths (though declining) are still exposing themselves to the risk of unplanned pregnancies, which given Nigeria’s high abortion and maternal mortality levels is very worrying. The results suggest that if unmet need were satisfied among this sub-population of women, contraceptive usage will increase to more than 50%. The result gives FP programmes and planners food for thought on actions to take to increase family planning usage. The high proportion of those who have not made their minds on future use of FP and are unsure of approval/disapproval of FP is a potential “soul winning” battleground for FP.

P1: 18

Unmet need for contraception in Assiut satellites: social or service problem?

Ghada Al-Attar, Omaima M.H. El-Gibaly, Farag M. Moftah, Maher S. Mohammad

Faculty of Medicine, Assiut University, Egypt; ghada_attar@yahoo.com

1. Background/Significance:

Although Egypt DHS, 2005 estimated that the highest unmet need for contraception was in rural Upper Egypt (17.0%) (El-Zanaty and Way, 2006), but it doesn’t disaggregate rural areas to mother villages and to the more remote health-services deprived areas (satellites). Information on the level of unmet need is frequently interpreted as an indicator of deficiencies in accessibility and quality of family planning programs (Shah et al., 2004). So this paper aims at estimating the level of contraceptive unmet needs in the satellites of Assiut governorate (one of Upper Egypt governorates) and its determinants.

2. Research: State main question/hypothesis:
Program: State intervention/activity tested

What is the level of unmet need for contraception in the remote rural areas (satellites) of Assiut (Upper Egypt governorate)? What are the reasons that explain the unmet in those service deprived areas? Is it a service accessibility or social factors problem?

3. Methodology (including location, setting, period, analysis approach)

A representative random sample of 474 currently married women (15 – 49 years) living in 16 of the satellites of Assiut governorate were selected by a multistage random sample via the CAPMAS. Women were interviewed via a semi-structured questionnaire at the year 2007 with quality control. Data entry was done via Excel program and analysis via SPSS version 11. Chi-square and logistic regression were the used significant tests.

4. Data (if relevant)

5. Findings

The unmet need for contraception in these remote deprived areas was high compared to the DHS estimated level in rural Upper Egypt. Social, demographic, service availability and other factors may explain the unmet need in these areas.

6. Research: State knowledge contribution
Program: State lessons learned
Efforts should be directed to women living in these remote deprived areas to address causes of unmet need. Moreover, strategies of offered family planning services in these areas need to be reconsidered.

P1: 19

Long Term Family Planning: Reaching the Hardly Reached Through the Private Sector

Dithan Kiragga, Barbara Addy, Ssenyondo Gonzaga Gonza
Health Initiatives for the Private Sector Project, Uganda; dkiragga@emg-hips.com

1. Background/Significance
The USAID funded HIPS (Health Initiatives for the Private Sector) Project works with the Uganda business community to find cost effective ways to ensure access to vital health services for company employees, their dependents and the surrounding communities. Our objective is to provide technical assistance to the private sector so that it can implement workplace health programs that maximize the accessibility of HIV/AIDS, TB, Family Planning (FP) & RH programs. Uganda has experienced a dramatic shift from a state driven to a private sector driven economy in the last 20 years with a resultant significant economic growth. The private sector now employs more that 80% of the “blue collar” workers in the country of which the majority are women. The workplace presents an excellent opportunity to engage staff on FP. However the health services provided as a free and readily accessible employment benefit for these employees, their immediate family and the surrounding communities by these companies has limited SRH Services more especially long term Family planning/contraception options. Long term Family planning (LTFP) is known to have economic benefits both to the employees and employer. Ignoring the role of the private sector as a significant SRH service provider and potential conduit for family planning may lead to lower use of long-term family planning methods among poor women.

2. Research: State main question/hypothesis
Program: State intervention/activity tested
The Program engages the private sector through mobilization and capacity building to scale up FP programs with a focus on the Long term and permanent methods. 10 major private sector estates/factories/enterprises in east, central and western parts of the country with a work force of a least 2,000-10,000 people and providing free health services to their workforce, dependents and surrounding community were identified. A preliminary facility assessment Survey using a detailed questionnaire on SRH was carried out for each of the health facilities on these estates/enterprises during the months of Feb.-March 2009. Overall contraceptive use, reliance on specific methods, availability of specific FP methods and sources of supplies were assessed. The staff capacity to provide LTFP Methods was also assessed. There after a 5 day intensive training in LTFP Methods –progesterin implant. Tubal ligation and IUD Insertion was done. Support supervision –6 weeks post-training was done for each of the facilities and data analyzed thereafter. The facilities were also supported with tubal ligation sets, insertion kits and start up LTFP supplies.

3. Methodology (including location, setting, period, analysis approach)
The program is conducted in 12 HIPS partner sites at Wagagai flowers, Kinyara sugar, James Finlays, Kakira sugar works, Tullow oil, Scool, Nile Breweries, Kyotera medical centre, Royal Van Zanten and TAMTECO. This training was conducted at the company health facility site. A total of 50 clinical staff were given skills in LTFP.

4. Data (if relevant)
Average facility contraceptive use was 10 clients per month for all methods. Majority (80%) of the facilities were not providing any of the long-term FP methods routinely on-site prior to the intervention. Most facilities were poorly equipped for IUD insertion and none was inserting implants. Only 10% of staff were confident in LTFP methods at the time of assessment. This rose to 89% after training. At the time of post training assessment contraceptive use had more than doubled in the participating facilities.

5. Findings
• There is a strong unmet need for FP especially for workers in the private sector
• An on-site training program is more cost-effective to health workers in the private sector.
• Theater facilities in the private sector need to be strengthened
• Staff in the private sector rarely get opportunities for further training and support from the MOH

6. Research: State knowledge contribution
Program: State lessons learned
• Efforts to increase contraceptive especially LTFP use among poor women need to involve the private sector.
• Leveraging company based resources supplements government services and expenditure.
• The workplace presents an excellent opportunity to scale up FP programs
• The program needs to work with the MOH to ensure the availability of FP supplies for enrolled clients
• There is need to integrate the program with other existing interventions for FP and RH

P1: 20

Increasing family planning uptake through Community awareness raising by peer educators in Sheder refugee camp, Somali Region of Ethiopia

Tirunesh Bune
International Rescue Committee, Ethiopia; tiruneshb@ethiopia.theirc.org

Background:
The International Rescue Committee in Ethiopia provides multi-sectoral humanitarian assistance in six refugee camps in Ethiopia; in addition, multi sectoral services are provided for internally displaced persons due to drought and floods as well as to local Ethiopian communities. The health program in the camps implements HIV/AIDS/STI prevention activities such as awareness raising, family planning service provision, HIV counselling and testing as well as eye care activities and disease surveillance. Working in partnership with the Administration of Refugee and Returnee Affairs (ARRA), the IRC interventions in the area of reproductive health have focussed on community based approaches.
Program purpose:
To improve the sexual and reproductive health knowledge and practices of Somali refugees through an integrated approach to reproductive health using peer educators. This has so far been targeted at improving family planning service uptake

Methodology:
This abstract will provide information related to Sheder refugee camp in the Somali region of Ethiopia which was opened in May 2008 and is home to 6666 Somali (3155 M, 3511F) refugees. The Somali refugees were found to have very strong cultural and religious values that made it difficult for them to accept reproductive health services. Therefore the IRC has tried to increase service uptake for family planning in this population by using different strategies.

Ten (8M, 2F) Social Workers who are all refugees were trained on pertinent issues surrounding HIV/AIDS and its transmission, STI prevention, safe motherhood, and family planning to enable them to pass on accurate information. These people are incredibly enthusiastic and committed to their role, conducting a high number of house-to-house visits as well as “coffee ceremonies”. The coffee ceremony is a focus group discussion held by groups of people sharing coffee.

Training was also provided for 60 (33M, 27F) Youth Health Club members on reproductive health and HIV/AIDS transmission and prevention. These individuals have assisted in health education among their peers by conducting house-to-house visits alongside the Social Workers as well as group discussions with youth.

Awareness raising campaigns were conducted that were facilitated by the IRC health officers supported by the youth health club members and social workers.

Male involvement: was done through two male focus groups that met regularly. This helped with men finding it easier to give permission for their wives to seek services. They also came with their wives to the clinics.

The social workers and youth club members initially found it difficult to talk to the community about condoms and family planning. They themselves did not want to touch the condoms or family planning methods. However, with persistent guidance and encouragement from the health officer they got more comfortable in their role. Numerous cultural barriers made talking about condoms and contraception to the community a challenge. This was eventually overcome by a “one to one” approach to health education and information sharing with the community with an emphasis on birth spacing and improved maternal health.

Data:
Between September 2008 and February 2009, the condom use by the community in Sheder improved drastically. A total of 9444 pieces of condoms were distributed through ten condom service outlets. Additionally, 30 women took up family planning methods during this period. More women are accepting referral to the ARRA health centre for long term family planning services. The table below shows the six month data for service uptake.

Best practice findings in Sheder:

- The use of Somali social workers who have been adequately trained, accept the messages that they need to pass on to their communities and engage on a daily basis with their peers can improve uptake of family planning and other reproductive health services.
- The confidentiality offered by the house visits and provision of methods within the household means that more people feel comfortable taking up services.
- Coffee ceremony discussions allow for community ownership of ideas and if these are well guided they can have a positive impact on service uptake.

P1: 21

Increasing access to safe abortion and post-abortion care by training midlevel providers

Paige Passano, Prata N.
UC Berkeley, United States of America; paigepassano.bixby@gmail.com

Background: The high unmet need for family planning, complicated by global shortages of skilled reproductive healthcare providers, is jeopardizing women’s health and lives. In an imperfect world, determinants such as poverty, low education, poor access to family planning, and oppression increase the likelihood of unintended pregnancies. In Africa, for example, approximately one third of pregnancies are unintended, and 40% of these result in abortions. The adverse physical, economic, and social consequences of unsafe abortion not only impact women but also affect the husbands, children, and elderly parents whose health and stability depends on the women who care for them.

The problem of unsafe abortion must be addressed from the supply and the demand side. On the supply side, the number and distribution of abortion seekers currently overwhelm the available pool of skilled providers, while on the demand side, there are places where unskilled providers enjoy a steady stream of clients despite the presence of skilled providers nearby. Women who choose unskilled over skilled providers may base decisions on cost, familiarity, or a desire to complete the abortion as quickly and quietly as possible. Insufficient awareness about which providers are skilled enough to safely perform abortions also contributes to adverse outcomes.

Laws permitting only physicians to perform abortions in specific facilities increase unsafe abortion rates because of the skewed distribution of physicians and facilities. Even where midlevel providers are allowed to perform abortions, lack of training opportunities create bottlenecks in the expansion of safer care. Governments have been slow to lift legal barriers despite compelling humanitarian and health concerns. Those who bear the heaviest burden of over-medicalization of abortion are the youngest, poorest, and least educated women. By expanding training opportunities to midlevel providers, governments can reduce the number of women who feel compelled to use desperate and unsafe methods because there is no other alternative.

Hypothesis: We hypothesize that mid-level providers can safely and effectively perform manual vacuum aspiration and medical abortion for first trimester abortions and post-abortion care.

Methodology: We reviewed the literature in PubMed and Medline from 1990 to 2009 on the safety and efficacy of training midlevel providers to conduct abortions or post-abortion care using manual vacuum aspiration or medical abortion. All studies conducted in Africa and Asia that evaluated the work of midlevel cadres in abortion provision and post-abortion care were included.

Findings: Midlevel providers such as medical officers, clinical officers, nurse-midwives, and others, if properly trained and supported, can be as effective as physicians in performing abortion and post abortion care. Randomized controlled trials conducted in South Africa and Vietnam concluded that midlevel cadres were able to provide first trimester abortions as safely as doctors with similar rates of client satisfaction. Of 7080 emergency surgeries conducted by tecnicos de cirurgia in Mozambique, including manual vacuum aspiration, caesarean sections, and hysterectomies, 90% were conducted successfully. Over a quarter of the surgeries were post abortion care to treat unsafe abortion. A South African study evaluating quality of abortion care conducted by registered nurses found that physician supervision was deemed no longer necessary because the performance of nurses was consistently high.
Efficient use of human resources necessitates the reorganization of abortion care into teams of midlevel providers and physicians. Simple, straight-forward cases should be handled by midlevel providers who are stationed closer to communities so the most experienced providers can manage complicated cases in facilities with adequate back-up support.

Lessons Learned:
By mastering the two skill sets of medical abortion and manual vacuum aspiration, midlevel cadres can safely provide abortion care, reducing costs and easing the pressure currently falling on the health care system. In regions where demand outweighs supply, pre-service and in-service training of midlevel providers should include comprehensive family planning provision, safe abortion, and post abortion care. In situations where reliance on untrained providers is high, the deployment of trained midlevel providers must be complemented by a robust educational campaign about the benefits of seeking abortion from trained over untrained providers.

Serious efforts to reduce abortion-related morbidity and mortality will require much greater flexibility in terms of where abortion and post-abortion care can be performed, and by whom. Policy change aiming to expand access to abortion-related care through training mid-level cadres, as observed in Vietnam, South Africa, Cambodia, Myanmar, and Ethiopia, is showing considerable promise in improving access to safe, high-quality abortion care. In evaluating the risks and benefits of task shifting for abortion and post abortion care, the consequences of unsafe abortion currently faced by women should be the point from which we measure improvements. Any change in law, policy, or practice with the potential to reduce abortion-related mortality and morbidity deserves serious consideration.

P1: 22

**Saving Maternal Lives: Finance and Delivery Strategies for Resource-Poor Settings**

Ndola Prata, Amita Sreenivas

UC Berkeley, United States of America; sreenivas@berkeley.edu

**OBJECTIVE:** This paper discusses financing and delivery strategies to carry out three priority safe motherhood interventions in low-resource settings founded on evidence that current state efforts are not reaching the poor. Recommendations are drawn based on where the poor go to access healthcare services and which strategies will be more likely to reach the poor effectively and quickly.

**BACKGROUND/SIGNIFICANCE:** In Prata et al. (2008), authors identified interventions that require minimal treatment or infrastructure, are not dependent on skilled providers, and will decrease maternal mortality in developing country settings. After assessing the potential number of maternal lives saved given program implementation, the three most effective interventions found were (i) improve access to contraception, (ii) reduce deaths from unsafe abortion, and (iii) increase access to misoprostol for the management of postpartum hemorrhage (PPH).

Although there is a significant body of evidence that points to the effectiveness of reducing maternal mortality by prioritizing these three strategies, such programs remain largely unavailable and underutilized by those who would benefit most—namely the poor. Lack of infrastructure, including human resources and necessary drugs and/or equipment is still very common in the public sector. This is especially true in rural areas—where skilled providers are lacking due to brain drain into more urban or industrialized regions, government-run clinic hours are often inadequate and unpredictable, and health facilities are extremely poor in quality (e.g. insufficient electricity or water). Even though state provision rather than management of healthcare services has been the main activity of many Ministries of Health in low-income countries, studies suggest subsidiary activities within developing countries tend to favor the finance of hospitals rather than primary care facilities. As the poor are less likely to access services at a hospital—largely due to distance—the rich are benefiting more from what is supposed to help the poor.

So this begs the question, where are the poor going for healthcare? In countries such as India, Vietnam, and Kenya, where >70% of the population live in rural areas, 85%, 60%, and 53% of health consultations, respectively, are made in the private sector. It is for reasons such as these that any national efforts to improve the health of marginalized populations must include the private sector. Today, the poor are increasingly reliant upon the private sector for healthcare due to lack of human and financial capacity of the public sector to ensure the availability and quality of health services. Therefore, it is imperative that the finance and delivery of the three priority safe motherhood interventions engage the private sector to reach the poor most.

**METHODOLOGY:** An extensive literature review was conducted to identify financing and delivery strategies that utilize the private sector through public-private partnerships and show an impact on improving access to healthcare services among the poor. Those strategies that excluded either the private or the public sector entirely were not included in our literature review.

After identifying possible strategies to leverage the private sector, those found to be cost-effective, scalable, and considerate of consumer behavior and ability to pay among the poor were examined to determine their suitability and potential for success in financing and delivering the three recommended safe motherhood interventions. To do so, each of the three priority safe motherhood interventions were considered individually in order to determine how each finance and delivery strategy could best increase access to the intervention among the poor.

**FINDINGS:** Working with the private sector can be extremely fruitful in reducing disparities and improving the health of the poor. After review of the literature, five strategies were found to be cost-effective, successful public-private sector engagements with the greatest potential for improving access to the three priority safe motherhood interventions: social marketing, community-based distribution of socially-marketed goods, contracting, performance-based assistance and social franchising. Social marketing and community-based distribution are appropriate avenues to increase availability and access for contraception and misoprostol. Both of these interventions and safe abortion services can be financed and delivered through social franchise networks, public contracting of private providers, and performance-based assistance strategies for public facilities.

**KNOWLEDGE CONTRIBUTION:** In order scale up the three recommended safe motherhood interventions in resource-poor settings, public-private partnerships are necessary. Leveraging the role of the private sector, through social marketing, social franchising, contracting, and community-based distribution, can be moderated and supported by shifting the role of the government from provider to steward in places where the public sector does not reach the poor. This will ensure that the suggested interventions are available among the most vulnerable populations.

**AO2: Reaching Youth: Programs for Adolescents**

**Time:** Monday, 16 November 2009: 11:30am - 1:00pm

**AO2: 1**

**A Holistic Approach to Reproductive Health Interventions: Talk 2 Me Case Study**

Oghenefego Onome Isikwenu, Rachel Jacobson, James Omokiti, Dosunmu Nurudeen

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Background
The upsurge of HIV/AIDS and other STIs world over and its alarming effect on young people has caused researchers, program managers, NGOs, governments and donors to seek ways of educating people about their sexuality and reproductive health.

Different methods have been proposed and used; they succeeded in some environments but not in all. Over the years it is making more sense that countries should localize strategies with changes that suite their native settings.

This is our experience with the Talk 2 Me project where a synergy of methods were brought together for improved results.

Objectives

- To provide opportunities for young people to discuss Reproductive Health (RH) issues on a monthly basis with their peers in school during Focused Group Discussion (FGD).
- To gather questions, concerns and observations from young people for professional answers and advice.
- To publish the questions and answers, reports from FGD and other articles in a newsletter format on a monthly basis.
- To distribute 1000 newspapers to young people in schools and churches in Delta State every month for six months.
- To educate 1000 adolescents on sexuality, RH, life-building skills and wealth creation.
- To challenge young people to bravely approach their parents with questions.

Intervention

Talk 2 Me project is a good example of putting knowledge to action and trying out best practices gained from conferences. This project was designed from the knowledge shared during the International Youth Conference on Public Health in Abuja, 2008 by Straight Talk Foundation Uganda. The idea was to use peer educators to facilitate discussions in secondary schools on sexuality, HIV/AIDS, STIs and other reproductive health issues. The innovative strategy was to get the stories of students as they were discussed and published them in a newsletter (Talk2Me) on a monthly basis. The newsletters were shared among young people in and out of school, so they could learn from what was discussed in the different school groups.

Methodology

The major tool used in gathering information were questionnaires and focused group discussions. Participants shared personal stories which were published. An editorial committee gathered the reports from the different groups and produced them as a newsletter (Talk2Me) on a monthly basis.

Results

The young people were very excited about the project and so looked forward to every meeting. A total of 10 schools participated in which 1000 youths benefited directly with over 5000 indirectly through the newsletter.

Peer educators reported an increased confidence and better relationship with students, since they came for counseling and asked personal questions. The stories shared increased because everyone wanted to show their family and friends the newsletter. At the end of the project, for sustainability a club (Champion’s Forum) was formed which meets once a month. This club consists of all secondary school students and even those out of school.

Conclusion/Recommendations

Young people are fun-loving, so every intervention targeting them should put this into account. They are in a state where their self-esteem and confidence is being built, so anything that gives them recognition and sense of belonging and contribution kindles their interest.

Traditional teaching methods should be scaled-up to more innovative and participatory methods to improve youth-friendly services.

A02: 2

Catalyzing Change: Lessons from DISHA: A program to promote Healthy Young people in India

Sushmita Mukherjee

International Center for Research on Women, India; smukherjee@icrw.org

1. Background/Significance: Reaching out to adolescents with quality service and usable information has always been a burning issue in any program aimed to address adolescent sexual and reproductive health. Bihar and Jharkhand in India has appalling poor statistics on major health indicators, young people are distanced from any services due to poor access, poor information and knowledge base and cultural taboos on adolescent sexuality. Here young girls particularly are challenged to secure a healthy future.

ICRW’s DISHA project on improving reproductive health of adolescents and young people developed an evaluation and intervention research project aimed to delay the age at marriage and childbearing among young people. The baseline data shows that 57% of girls (14-20 years) are married, and the average age at first birth is 18.2 years. Only 11.5% of married girls have ever used a family planning method to delay the birth of a second child, and less than 57% had an ANC check-up during their 1st pregnancy. This low use of RH services is explained, in part, by poor ASRH knowledge: almost a quarter of female respondents did not know about modern FP methods and 54% did not know where to find at least one modern method. A conservative familial/social environment compounds the situation, with 46% of adults disapproving of the use of family planning methods to delay first pregnancy for young couples and 74% of adults disapproving of young girls having information on sexual matters before marriage. For young girls, restrictions on mobility – even within their village – are strong, with 46% reporting that they cannot seek treatment when sick.

2. Research: State main question/hypothesis Did DISHA improve youth access to reproductive health services through greater involvement of young people themselves?

3. Methodology (including location, setting, period, analysis approach): To test the effectiveness of DISHA’s integrated program, ICRW selected a rigorous quasi-experimental research design with six study and two control sites across the two states. The project’s implementation period of 24 months was framed by in-depth baseline and endline assessments, using both qualitative and quantitative methods. Baseline and endline surveys were conducted with male/female youth and adults in all sites. Endline qualitative data collection included a total of 34 focus group discussions with female/male youth, female/male adults, and health service providers. The impact evaluation of the DISHA intervention package was done using descriptive information on a range of variables including youth reproductive health knowledge, utilization of reproductive health services, youth empowerment (e.g. communication and mobility related to accessing services) and adult support of ASRH needs.
4. Data (if relevant):
   a. Our endline shows age at marriage for girls increased nearly two years from 15.9 to 17.9 years due to the intervention.
   b. Contraceptive use increased among youth by nearly 60 percent.
   c. Youth exposed to DISHA were 17 percent more likely to know where to access oral contraceptive pills than non-exposed youth.

5. Findings: Findings as drawn from project monitoring and evaluation data indicates that positive changes have occurred with many of the factors that influence youth uptake of SRH services. Youth report increases in knowledge and understanding of RH issues and increased access to sources of RH products and services. Data suggests an increase in use of contraceptives and other reproductive health services by boys and girls, married and unmarried – a finding that is supported by health providers input as well. There is also qualitative evidence of greater client satisfaction in services provided by peer educators and local private practitioners who underwent training on the provision of youth-friendly services, and were identified by youth themselves to provide improvised services. Both youth and adults also report a shift in parental and community attitudes, with greater recognition of youth needs and support for youth access to and use of RH services. Our data also identified youth as an important resource in defining and meeting their sexual and reproductive health needs and their involvement brings success especially when through platforms like peer networks they reach out to larger youth population with knowledge and services.

6. Research: State knowledge contribution

Analysis of the DISHA program shows that integrated programming does work to increase youth access to and use of SRH services. The value of peer outreach – especially in reaching such highly marginalized segments of the population - has also been demonstrated. Youth depot holders provide youth with confidential, personalized services which allows young girls to demonstrate agency and control over their reproductive lives and choices in a patriarchal and conservative social context. There are innovative ways in which young peer depot holders can garner adult support for increased access to reproductive health information and services for youth. Training private practitioners within the community in youth-friendly service provision improves youth utilization of reproductive health services in settings that have poorly equipped and insensitive public health systems.

A02: 3

Using private sector funded mass media campaign and NGO alliances to reach FP/RH underserved women and youth in Guatemala

Maria Teresa Ligoria

RTI International, Guatemala; tligoria@rti.org

Background/Significance: Despite that fact that its total fertility rate is the second highest in the region, at 4.4 children per woman, critical reproductive health information is still not available for rural uneducated women and youth. Currently, the unmet need of contraceptive methods is 27%, with a higher proportion in indigenous, rural communities. Although the National Family Planning Law was passed in 2006, it is still not operational and key elements such as incorporating sexual and reproductive health curricula into public schools and training teachers have not been implemented.

Through a public private partnership, RTI designed, produced and carried out a mass media campaign to raise the level of exposure and awareness in the general public of critical RH issues. RTI engaged the private sector in an unprecedented effort to fund, publicly support and widely disseminate RH messages, thus supporting public health programs and augmenting the work of the MOH. Simultaneously, RTI formed a national FP/RH Alliance with five existing NGOs working in providing family planning and reproductive health information, services and referrals to rural, young and poor women and men. The RH alliance enhances the work of each NGO, allowing them to achieve their objectives more efficiently than if they operated individually.

Hypothesis or Intervention/Activity Tested: The national mass media campaign, which started in February 2008, contained three messages: 1) Optimal birth spacing; 2) Prevention of teen pregnancy; and, 3) Exclusive breastfeeding. The target populations for each of the three messages were, respectively: 1) Women of reproductive age who are pregnant, planning to be pregnant or have not spaced their pregnancies in an optimal manner; 2) Teenage females between the ages of 14 and 19 and; 3) Recent and pregnant mothers who are not currently breastfeeding or who are not planning to continue exclusive breastfeeding for the first six months.

Methodology: Public service announcements (PSAs) were pre-tested in nine focus groups, mainly low socio-economic classes, in rural and urban areas. The levels of acceptability and identification with the messages were 100% for breastfeeding; 94% for birth spacing and 86% for prevention of teenage pregnancy. The messages were revised and aired for three weeks each on national television and radio stations. They were aired in Spanish on TV and additionally in four Mayan languages on radio. Also, copies of the PSAs were provided to all of the partners for distribution.

Findings:

Based on evaluations by the media, 1 million people were exposed to the messages through the media campaign. Dichter & Neira were contracted to evaluate the exposure and impact of the disseminated PSAs. To date, two of these messages have been evaluated. The preliminary results suggests that for these who were exposed to the media campaign messages, 86% can recognize the importance of birth spacing and 68% can recognize the importance of family planning. The third message will be evaluated later this year. For Guatemala, the average level of recognition of a PSA is 44%, therefore the results suggest that there was a significant impact on those who have exposed to the messages.

Partners reported that the PSAs had been used extensively and continuously. PSAs were shared with the National Reproductive Health Program and delivered to all of the national hospitals which have in turn used them as a tool in the post-partum FP strategy. Another USAID funded program has begun using it as part of the educational curricula in the local nursing schools.

During the past quarter, 5,273 persons were exposed to a FP/RH message through the varied RH Alliance implementations. In addition, 2,635 persons were trained in FP/RH by the implementing members of the alliance. Another significant result is the percentage of persons with knowledge in FP/RH is measured at 77%. These numbers suggest that the RH Alliance has improved the access to appropriate FP/RH information and services in the rural areas.

Knowledge contribution or lessons learned: Preliminary results seem to suggest that the mass media campaigns designed to increase the awareness of important FP/RH messages for the underserved population in Guatemala are effective, although Guatemala continues to be a traditional, conservative country. They also serve as a vehicle for nontraditional actors in health, specifically private sector corporations and other for profit entities, to support public health messages and in doing so raise awareness of FP/RH issues of the underserved population. These non traditional actors may later become a significant source of funding and outreach for government health programs, especially those that can be implemented in working environments or with workers’ families. Bringing together recognized and successful organizations to work as a team and standardizing materials and indicators to measure, allow more efficient use of resources and collection of more significant data.
Giving young women in Kenya an opportunity to use contraceptive implants instead of short-acting methods: preliminary results on acceptability

David Hubacher1, Alice Olawo2, Caroline Kemunto3, James Kiarie4

1Family Health International, United States of America; 2Family Health International, Kenya; 3University of Nairobi Institute of Tropical and Infectious Diseases; dhubacher@fhi.org

1. Background/Significance

New approaches to provision of long-acting contraceptive implants are needed to help reduce the high levels of unintended pregnancy that persist in sub-Saharan Africa, especially among women under 25 years of age. This age group alone is expected to experience 44% of the 43 million unintended pregnancies that will occur in the region between 2005 and 2010. Cultural pressures to bear children at an early age make young women particularly vulnerable to unintended pregnancy. In Kenya, women under 25 years of age report that approximately 42% of their pregnancies are unintended.

Because of possible ambivalence toward future pregnancy, many young women may have undetermined or initial short-term contraceptive needs (4-12 months) when they seek services. They may not naturally request long-acting implants for pregnancy protection and instead, self-select toward short-term methods; this often sets them on a path toward unintended pregnancy. Short-term methods are difficult to use consistently and correctly; when side effects arise and/or when actions are needed to continue using these methods, ambivalence toward pregnancy can prevail and lead to early method discontinuation. Unintended pregnancies in this population can limit educational opportunities for life, affect desires to gain employment outside the home, and prevent realization of other goals. More effort is needed to help this age group overcome ambivalence toward pregnancy and take better control of their reproductive health; better contraceptive options may be one possible solution.

2. Hypotheses

Our aim was to measure uptake and continued use of subdermal implants in a young Kenyan population and to compare this to uptake/use of short-acting methods such as oral and injectable contraception. The main hypotheses are shown below:

- A substantial proportion of women will welcome the opportunity to use an implant instead of the alternatives
- Women opting for short-acting methods will stop using the methods earlier than women opting for an implant, despite having similar fertility prevention goals
- Women who initially get an implant will avoid unintended pregnancy to a much greater extent than women who initially get a short-acting method

3. Methodology

We conducted a prospective study of 400 women aged 18-24 who sought injectable or oral contraceptives at one government clinic in Nairobi, Kenya. Recruitment began in November 2008 and ended in 2009; we excluded women who specifically sought an implant. After counseling and informed consent, some women voluntarily chose an implant (Jadelle) and others chose the method they originally wanted. We collected baseline information on user characteristics and attitudinal data on factors that might influence the decision to stop using the chosen contraceptive. We conducted phone interviews with the participants at one- and six-months to get information on current method use and side effects.

4. Data

We used data from the admission and follow-up forms to better understand factors associated with choice of method and contraceptive use patterns.

5. Findings

We screened approximately 800 women on the various eligibility criteria to successfully recruit 400 participants into the study. Twelve percent of the study population was aged 18-19. Less than 5% of the study population was nulliparous, 50% had one previous pregnancy, and the remainder had 2+ previous pregnancies. At the time of enrollment, half of the study population felt that the body needs a break from hormonal contraception every once in a while and one-third felt that prolonged use would impair future fertility. Ninety percent of participants said that it was easy to return to the clinic for more contraceptives. Nearly 60% had experienced an unintended pregnancy previously.

Women chose methods in the following proportions: oral contraceptives (10%), injectable (65%), and implant (25%). More than half of the women who stated it was difficult to return to the clinic chose the implant. At the time of the one-month follow-up interview, nearly all participants were still using their method; results from the six-month interview are pending. (By the time of the November 2009 presentation in Uganda, six-month data will be available for 300 of the 400 participants.)

6. Knowledge Contribution

Young women who seek short-acting reversible methods are perfectly good candidates to adopt a longer-acting method, if they receive the proper information and make an informed choice. Even women who have never used hormonal contraception may be acceptable candidates for a contraceptive implant. These preliminary findings have documented uptake and high levels of satisfaction with an implant, among a young population. Alternative contraceptive regimens may not provide the same level of protection from unintended pregnancy. Longer-term follow-up and more data from the cohort will be needed to confirm this hypothesis; follow-up will continue through 2010.

A02: 5

Knowledge, Perception and Attitudes of Refugee youths in Oru refugee camp, Nigeria towards contraceptive use

Kehinde Ololuwado Okanlawon

Obafemi Awolowo University, Ile Ife, Nigeria; okanlawon_kehinde@yahoo.com

KNOWLEDGE, PERCEPTION AND ATTITUDES OF REFUGEE YOUTHS IN ORU REFUGEE CAMP, NIGERIA TOWARDS CONTRACEPTIVE USE

Okanlawon Kehinde (okanlawon_kehinde@yahoo.com)

Background/Significance: Refugees are among the world’s most vulnerable persons. They often have urgent health needs which may be unmet or neglected in emergency situations. Refugees may have far less access to contraception because services and supplies have been disrupted. However, this can result in unwanted pregnancies; rising abortion rates and high risk births in poor resource settings such as refugee camps. Oru refugee camp has hosted refugees for about 20 years. Studies show that young refugees in this camp face a host of social and economic challenges. With poverty a stark reality in this camp and many young female refugees engaging in transactional sex in order to obtain their survival needs, the need to address the reproductive health challenges confronting these young refugees is great. The United Nations Humanitarian Commissioner for Refugees has identified teenage pregnancy as a big problem in Oru camp
and this point to unacceptable prevalence of sexual practices among these displaced youth. This is an indication of the need for improved understanding of some factors which can help prevent large number of unwanted pregnancies among youths in the camp such as their knowledge, attitudes, access and use of contraceptives. Better understanding of these factors will help in improving outcomes of existing programmatic interventions.

Objectives: The study sought to determine the perception, knowledge and attitudes of refugee youths in Oru camp towards contraceptive use and also to determine their access to contraceptives and its use in the camp.

Methodology: The study was conducted in Oru refugee camp between December 2008 and January 2009. We utilized both quantitative and qualitative methods. Respondents were chosen from 10 – 24 year age group through household survey and systematic sampling was used. 208 respondents participated in the survey. Questionnaires were individually checked for completeness, coded and subsequently analyzed using SPSS version 13. Basic descriptive analysis of the data was performed using a frequency distribution. Focus groups and interviews were also analyzed.

Findings: Of the 208 refugees in the study, 55.8% were female and 44.2% were male. The analysis of contraceptive knowledge among them shows that knowledge of contraceptives was high in all age groups. Almost all respondents know at least two modern contraceptive methods. Everyone has heard of condoms. Awareness about the risk of unwanted pregnancy through unprotected sex was also high among these refugees but despite this knowledge, they do not connect risk perception to behavior. 68% of young female refugees including those between ages 13 – 15 years have had unprotected sex at least twice within the camp without using any contraceptive. 48% of the female refugees studied are mothers between the ages of 15 – 24 years. Most have dropped out of school due to unwanted pregnancy. During interviews and FGD, we asked these young mothers whether they wanted the pregnancies at the time they had them and about 90% said they didn’t want it. They kept on saying: “It was a mistake”. A 19 year old female said:

“I didn’t know it would happen. I wasn’t ready to have a child at that time. I still regret not using contraceptive then because the baby I gave birth to is suffering in the camp”

Many believe contraceptives are dangerous and that chemicals in contraceptives cause damage to the reproductive system. A 22 year old female said:

“I can’t risk my life by using contraceptives, they are dangerous. I know a woman in this camp who died due to adverse effects of contraceptives. Nurses are wicked. They don’t tell people about the side effects. They just tell us to use it.”

Respondents all mentioned that they have access to condoms in the camp however, many complained about inadequate access to other contraceptives. A 24 year old said:

“Before, contraceptives like pills, IUD, injectables, etc were free in this camp but since the camp clinic was closed in 2005, we now go to hospitals in the host community to buy contraceptives, its no longer free. Some of us like to use it but we can’t get it in the camp. That’s the problem”.

Most respondents believe condom is safer than other contraceptives but condom use was still low among them. Only about 40% of them used it at last sex.

Non-users mentioned reasons such as: partner objected, don’t like them and didn’t think it was necessary.

Knowledge Contribution: The findings demonstrate the existence of serious challenges such as ignorance, poverty, inadequate access to information and contraceptives among refugees. This highlights their extreme vulnerability and points to their need for education and information about behavior change to increase their awareness of reproductive health issues. The findings reiterate the need for interventions to provide contraceptives and other family planning products and services for refugees to improve their lives.

B02: Contraceptive Use: Levels and Trends

Time: Monday, 16 November 2009: 11:30am - 1:00pm

B02: 1

Contraceptive Use among at-risk women in the Kumasi metropolis of Ghana.

Baafoor Opoku

KNUST, Ghana; baafooropoku@yahoo.com

Objective: To look at the prevalence of contraceptive use among women considered to be at risk of acquiring sexually transmitted infections in the Kumasi metropolis.

Design: Structured interviews of ‘at-risk’ women between ages 18-35 years (inclusive) who consented to be interviewed.

Participants: Women aged between 18-35 years (inclusive) who were having at least 3 sex acts per week and had had at least 2 sex partners in the previous 3 months and were willing to be part of the study. One thousand and seventy (1070) women participated in the study.

Results: Whilst awareness of methods of contraception was 96.4%, usage was 50%. The male condom was the commonest form of contraception, reported by 32% of respondents. None had used the female condom before. A mean of 5.7 coital acts in the previous week was found and an average of 3 sexual partners in the previous 3 months. About 12% and 42% engaged in anal and oral sex respectively.

Almost 4% were using Primolut ‘N’ (Norethisterone) in various dosages as a form of emergency contraception.

Conclusion: Social marketing groups involved with the promotion and distribution of contraceptives in the country need to step up their activities among women at greater risk of acquiring STIs and unintended pregnancies. The use of Primolut ‘N’ as a form of contraception needs further study.

Keywords: Contraceptives, at-risk women, unintended pregnancies, sexually-transmitted infections.

B02: 2


Kouassi De Syg Seku, Habibou Ouedraogo

Institut de Formation et de Recherche Démographiques, Cameroon; sekedesyg@yahoo.fr

1. Contexte/Importance ;
Malgré l’engagement politique du Cameroun en faveur de la promotion de la planification familiale, force est de constater que jusqu’à nos jours, la proportion de femmes mariées âgées de 15 à 49 ans utilisatrices de contraception toute méthode confondue reste faible (26%, Population Reference Bureau) et une proportion non négligeable de femmes éprouvent encore des besoins non satisfaits en planification familiale (14,5%, EDS 2004).

2. Recherche : Indiquer la question/hypothèse principale ;

Sur la base de la théorie et des travaux antérieurs, nous formulons et testons 3 hypothèses :

H1 : Des divers facteurs qui influencent significativement sur les besoins non satisfaits de planification familiale, ceux qui servent à caractériser individuellement la femme (milieu de socialisation, niveau d’instruction, religion) et certains aspects de la fécondité (nombre d’enfants en vie) et certaines variables socioculturelles du mari, (niveau d’instruction, la co-résidence du conjoint) sont les plus déterminants.

H2 : La connaissance de la contraception par les femmes ainsi que l’attitude de ces dernières vis-à-vis de l’approbation de l’usage de la planification familiale influence positivement le niveau des besoins non satisfaits en matière de planification familiale.

H3 : Le dialogue et la convergence de vue entre conjoints (discussions sur les méthodes de planification familiale, attitude du mari face à la planification familiale, le nombre d’enfants désirés par le couple) sont des facteurs importants des besoins-non satisfaits.

3. Méthodologie (y compris le lieu, la situation, la période, l’approche adoptée pour l’analyse);


4. Données (s’il y a lieu) ;


5. Conclusions ;

Les facteurs les plus pertinents et donc les déterminants expliquant la probabilité d’avoir un besoin non satisfait de planification familiale, sont, par ordre d’importance au seuil de 1% : la co-résidence du conjoint (23,5%), la religion de la femme (15,7%), le nombre d’enfants vivants (11,6%), le niveau d’instruction du mari (9,13%), le niveau d’instruction de la femme (7,30%), le milieu de socialisation de la femme (3,3%) et l’approbation de la planification familiale par la femme (2,4%). C’est dire que, les résultats confirment l’hypothèse H1, infirment l’hypothèse H3 et vérifient partiellement l’hypothèse H2 pour l’attitude des femmes vis-à-vis de l’approbation de l’usage de la planification familiale.

6. Recherche : Indiquer la contribution aux connaissances ;

Sur la base de ces résultats nous formulons quelques recommandations d’actions spécifiques dans le cadre des programmes nationaux de planification familiale : notamment des actions en vue d’intensifier et vulgariser les méthodes modernes de contraception ; des campagnes d’IEC pour encourager une nécessaire implication tant des femmes que des conjoints dans la discussion et l’usage de la planification familiale ; la promotion d’une prise de conscience en faveur de la scolarisation des filles futures mères et donc appelées à être utilisatrices de produits de planification familiale.

B02: 3

Multilevel analysis of unmet need for contraception in Urban Nigeria

Latifat Ibisomi, Jean-Christophe Foto, Michael Mutua

African Population and Health Research Center, Kenya; libisomi@yahoo.com

Background: The concept of unmet need points to the observed gap between the reproductive intentions of individuals and their contraceptive practice. The assessment of levels of unmet need and hence, demand for contraception is of importance to population and health policy makers and programmers for the purpose of defining targets (Ross, 1994; Sinding, 1994). Understanding the factors that are associated with unmet need also provides the basis for identifying strategies to increase demand for contraception and prioritizing of family planning efforts.

In recent years, research interest has shifted to looking at how community characteristics influence issues around contraceptive behavior(s) as against the traditional way of focusing on personal characteristics of individuals. This is drawing from the perspective that argues that the ideational characteristics of communities’ determinants sexual attitudes and behaviours as communities influence them through social norms and informal social controls. However, very little evidence exists in developing countries on the level, pattern and determinants of unmet need for contraception among urban women and in particular, how community characteristics impact on this important reproductive health indicator.

Hypothesis: The characteristics of communities where women live have influences on their individual unmet need for contraception, above and beyond their own characteristics.

Methods and Data: We use the 2003 Nigeria Demographic and Health Survey (DHS) to examine the magnitude of unmet need for contraception among urban women, and identify its state- and individual-level covariates. We take advantage of the presence of 36 states in Nigeria to adopt a two-stage approach. First, we conduct state-level analysis to identify covariates of state-level unmet need for family planning. The state-level variables to explore include interpersonal family planning discussion, approval, use and knowledge as well as religion, income and education. At this level, the mean numbers of people that have knowledge of, use modern method, approve or discussed family planning issue with anybody in each state are used to represent the state level characteristic.

In addition, the proportion that are Christians, mean urban household income and proportion with senior secondary education and above in each state are used as the state level religion, income and educational attainment, respectively. Second, we conduct multilevel logistic regression modeling to examine the effects of individual (micro) and community (macro) levels characteristics on unmet need for contraception. At the macro level of analysis, the covariates include: age, number of living children, marital status, education, wealth, discussion of family planning and employment status.

Preliminary findings: Our results show that unmet need for contraception among women in urban Nigeria is about 43% and this varies widely between the 37 States. Bivariate analyses also shows that all the macro and micro levels characteristics except employment status were singly associated with unmet need for contraception. At the macro level, results shows that women that have knowledge of modern methods of, those that approve family planning and those that are Christians are less likely to have unmet need for family planning in urban Nigeria while women that had interpersonal communication on family planning and those with senior secondary or higher level of education are (insignificantly) more likely to have unmet need for contraception.

In the multilevel model that combined the two levels characteristics, all the individual characteristics remained statistically significant while discussion and knowledge of family planning as well as being a Christian in addition to approval of family planning became statistically significant. Macro level knowledge, approval and state interpersonal communication on family planning as well as being Christian and having senior secondary level and higher education were all associated with less likelihood of unmet need for contraception. The macro level characteristics that were significant are the number of living children, being
married, in employment and non-poor. The odds of having unmet need for family planning increases with each surviving child and is more likely among currently married women especially those in polygamous union compared to women that are not in union.

Knowledge contribution: The observed high percentage of women experiencing unmet need for contraception in urban Nigeria is an indication of the population in dire need of contraceptive service(s) to enable them achieve their reproductive intentions. The multilevel logistic analyses further identified micro and macro level characteristics of the people and community with unmet need for family planning. These are of utmost importance to policies and programmes for identifying further strategies to meet this demand for contraception and for prioritizing family planning issues in general. The findings will further be discussed against the major family planning and reproductive health policies and programs implemented in the country over the last decade.

B02: 4

Unmet and met Need for Contraception in Ethiopia; levels and trends; Evidence from DHS

Solomon Shiferaw Yesuf, Genene Bizuneh, Yilma Melkamu
School of Public Health, Addis Ababa University; Ethiopia; soloshi@yahoo.com

1. Background/Significance

With a population of 77 million, Ethiopia is the second most populous country in Africa with rapid population growth rate at 2.6 percent per annum. The majority of the population (85 percent) resides in rural areas and is largely engaged in small scale, traditional farming, which is highly dependent on rainfall. The population is young, with more than 40 percent below the age of 15 which signifies the potential for considerable growth.

2. Research: State main question/hypothesis

The present paper tried to address two important research questions; namely examining the trends and predictors of unmet need between Ethiopian DHS 2000 and 2005.

3. Methodology (including location, setting, period, analysis approach)


The analyses is restricted to fecund nonusers of contraception who express a desire to space or limit the number of children they want (those with an unmet need) and those who have a met need, that is, those who are currently using contraception. Excluded from these analyses are women who want another child within two years and infecund and menopausal women. These women total 4,291 for 2000 and 4,402 for 2005 when weighted. Outcome variables for the multivariate model were total unmet need, unmet need for spacing and unmet need for limiting the number of children.

4. Data (if relevant): described under methodology

5. Findings

Figure 1 presents changes between 2000 and 2005 in unmet need, current use, demand for family planning, and demand satisfied among currently married women in Ethiopia. Unmet need has declined only slightly from 36 percent in 2000 to 34 percent in 2005. Interestingly, there was almost no change in the levels of unmet need for limiting and a relatively small decline in unmet need for spacing in the five years between 2000 and 2005. In contrast, the proportion of currently married women who use contraceptive methods nearly doubled from 8 percent in 2000 to 15 percent in 2005. This increase was more pronounced for limiting than spacing methods.

Multivariate Analysis: Multiple multinomial logistic regression analyses was carried out to identify independent predictors of total unmet need, as well as unmet need for spacing and unmet need for limiting separately (Tables 2 and 3).

In agreement with findings from the 2000 survey, the youngest age groups were significantly more likely to have unmet need in 2005. A separate regression model run to identify factors related to unmet need for spacing and limiting also showed a comparable trend in the two surveys. Younger women were generally more likely to have unmet need for spacing while the older women were more likely to have unmet need for limiting. Findings from both surveys indicate that urban residents were significantly less likely to have total unmet need compared to rural women. Nevertheless, the marked urban-rural difference disappeared when the analysis was done for spacing and limiting separately in both surveys.

6. Research: State knowledge contribution

The analysis shows that unmet need remained high, at 34 percent during the five-year period between the two surveys, as indicated by a decline of only 2 percent from the 2000 survey. On the other hand, contraceptive prevalence has improved substantially over the five years (from 8 percent to 15 percent).

The total demand satisfied for family planning averaged 31 percent in 2005 which shows some improvement compared to the 18 percent in 2000. It is noteworthy to mention that only a quarter of the demand for spacing is satisfied, although it constitutes the larger portion of unmet demand.

The findings indicate the need to strengthen community level family planning activities particularly in the rural areas as most of the women with unmet need who are uneducated, unemployed and those with high fertility are rural residents. Further, relevant stakeholders should work to improve the method mix as women should get the right methods for the right intentions; limiting and spacing.

B02: 5

Déterminants de l’utilisation des méthodes contraceptifs moderne chez les femmes béninoises

Guy Franck Biaou Alé1, Amour Ayedélé Balogoun2
1Population Services International (PSI), Benin; 2Population Services International (PSI), Benin; fale@psibenin.org

1. Contexte et justification

Au Bénin, la fécondité reste très élevée et beaucoup de jeune fille ont des enfants très tôt selon l’Enquête Demographique de Santé. Les besoins non satisfaits en matière de contraception selon cette même étude est de (30%). Cette situation est préoccupante si on sait que le d’utilisation des méthodes contraceptives modernes est très faible (6,9 % selon l’EDS 2006). Pour améliorer cette situation PSI-Bénin sollicite auprès de l’USAID un appui pour financer un projet intégré de planification familiale.

Dans le cadre de lancement de ce projet entre mai et juillet 2008, PSI-Bénin a initié une étude de base sur les déterminants de l’utilisation des méthodes des contraceptifs modernes au Bénin afin de développé des stratégies marketing et communication pour améliorer le taux d’utilisation des méthodes auprès des
femmes beninoises en besoins de contraception. Cette étude s’est déroulée dans sept communes du Bénin. La population cible est constitué des femmes de 15-49 ans ayant besoin d’une méthode contraceptive.

2. Recherche :

*Question de recherche

Quels sont les facteurs qui discriminent les utilisateurs et les non utilisateurs des méthodes modernes de contraception au Bénin ?

*hypothèse principale :Les interventions sur ces facteurs de différences donne un impact positif sur la conversion des non utilisatrices en utilisatrices et augmenter ainsi les chances de succès du projet.

Programme :

Le programme de planification familiale de PSI-Bénin mène sur financement de USAID des activités de marketing sociale des produit Equilibre(injectables 3 mois et Harmonie(pilule comprimé) afin de rendre ces produits disponibles et accessibles aux populations pauvres et vulnérables. Pour aussi les motiver à utiliser ces produits ou autres services de planning familiale PSI développe des activités de communication (communication interpersonnel et mass media) avec l’appui des ONG locaux et des radios locales. De même un système de franchise sociale au niveau des cliniques(38) est mise en place pour faciliter l’accès aux services de qualité.

3. Méthodologie :


4. Données

Il ressort de cette étude que quatre principaux facteurs discriminent les femmes utilisatrices de méthodes contraceptives modernes et les non utilisatrices.

Au niveau des facteurs psychographiques,les femmes ayant le soutien de leur partenaire sont plus nombreuses parmi les utilisatrices que les non utilisatrices (34,1% versus 66,4%) (p<0,001, OR=4). Les femmes ayant une bonne connaissance méthode contraceptive sont plus enclins à être utilisatrice des méthodes (97,5% versus 85,7%) que non utilisatrices (p<0,001, OR=3). Les femmes qui rejettent les mauvaises croyances relatives aux effets négatifs des méthodes modernes de contraception sont aussi enclins à l’utilisation d’une méthode contraceptive moderne (p<0,001, OR=2). Il en est de même que pour celles qui ont un accès facile aux produits de planification familiale et celles qui sont instruites (p<0,001, OR=2).

Au niveau des facteurs socio-demographiques notons que le niveau d'instruction discriminent les utilisatrices (49,8%) des non utilisatrices (30,7%) (p<0,001, OR=2).

5. Conclusions

Pour améliorer le niveau d’utilisation des contraceptifs modernes au Bénin, il importe que les produits de planification familiale soient disponibles. Aussi faut-il développer les activités pour informer les femmes sur la gammes variées des méthodes existantes et leur avantage. L’identification de l'instruction comme déterminants de l’utilisation des méthodes modernes de contraception montrent que le programme de planification familiale atteint beaucoup plus les femmes instruites or au Bénin ce groupe est minoritaire. Il est donc important que toutes les activités de communication soient réorientées vers les cibles majoritaires qui sont les non instruites.

6. Recherche/Programme :

Grâce à cette étude, PSI-Bénin a identifié facteurs sur lequels les actions de communication et de marketing social doivent être menées pour amener les femmes ayant besoin de contraception non utilisatrices à devenir des utilisatrices et donc à améliorer la prévalence contraceptive au Benin.

Cette étude montre clairement que la décision d’utilisation des produits de contraception par la femme est conditionnée par le soutien de son partenaire. Des activités visant à impliquées les hommes dans la planification familiale doivent être développées. L'autoéfficacité des femmes à reconnaître et à rejeter les idées fausses sur le planning familial notamment la connaissance de leur caractère réversible est aussi très important dans la décision d'utiliser les méthodes. Il importe donc qu’un système de gestion des rumeurs et d’assistance aux femmes en information soit mise en place.

Les activités de communication pour la santé et marketing des produits devraient cibler pour avoir plus d'impact les femmes non instruit qui sont moins utilisatrices.

OR = old ratio

CO2: Psycho-social Aspects of FP

Time: Monday, 16 November 2009: 11:30am - 1:00pm

CO2: 1

Factors influencing family planning choices among women in the Hohoe district of Ghana.

Easmon Otuor1, Charity Vivian Mote2, Harry Tagbor1, Ernestina Ofiriwaa Alowuah3

1Kwame Nkrumah University of Science and Technology-School of Medical Sciences, Ghana; 2Ghana Health Service, Hohoe, Ghana; easmono@yahoo.com

Background: Family planning (FP) methods are important for sexual health and well-being and they remain one of the most cost-effective public health interventions available in developing countries to lower rates of maternal and infant mortality and promote economic growth.

Hohoe district has a population of 171345 (growth rate of 1.9%). Current contraceptive prevalence is 24% for both modern and traditional methods. Knowing the factors associated with FP-use and non-use is fundamental to designing, implementing and evaluating interventions to improve uptake.

Hypothesis/Intervention/Activity Tested

We aimed to determine the socio-economic and demographic factors associated with FP-use by women aged 15-49 years in the Hohoe district.

Methodology: Hohoe district is one of the 15 districts in the Volta Region of Ghana. Six health sub-districts cover 152 communities. Health facilities include: 2 hospitals, 26 health centres, 3 health compounds and 4 private clinics.
We collected data from 408 women aged 15-49 years irrespective of their marital status. The study period was July – October, 2008. Structured questionnaires were administered to respondents in Ewe (native language) or in English. Ethical clearance was obtained from the internal review board of the Hocho District Health Administration. Multi-stage random sampling was used to select respondents who enrolled into the study after informed verbal consent. Questionnaires were checked for completeness, consistency and internal errors daily. The data were double-entered into Epi Info Version 6 (CDC, Atlanta) which was used for analyses.

Results: Respondents’ mean age was 29.9 years and more than half (58.8%) were married. The sample was overwhelmingly Christian (93.9%), reflecting the composition of the district. Most respondents had a basic level of education, were peri-urban residents and were self-employed.

Nearly two-fifths (43.9%) of respondents used any method of FP; 25.5% used a modern method. Among the users of any contraceptive those aged 20-24 years (24.58%) had the highest rate of use; of the 25.5% of modern method users, those aged 20-24 (22.1%) and 30-34 years (22.1%) had the highest rate of use. Over half of current FP-users (all methods) were married (54.7%) and over two-thirds of modern method users were married (67.2%). Most FP-users and non-users had a basic level of education (up to Junior High School). Among FP-users (any method), those with any form of education (92.7%) and peri-urban dwellers (65.4%) were better users of family planning. Users of modern methods were more likely to have at least a junior high school education (84%).

Place of residence was statistically associated with FP-use (p-value=0.0001) with peri-urban dwellers having statistically higher levels of use compared with urban and rural women. Of FP-users, the self-employed (68.7%) more than the employed (8.9%), unemployed (14%) or housewife (8.4%) were the more likely user. Employment was associated with contraception (p-value for trend = 0.01)

Most respondents had one-two children alive. Nearly three-quarters (74.9%) of users (any method) had one or more children. Those who had one or more children were more likely to use a modern method (75%) compared with women of higher parity. Among the users of any method, 35.8% did not desire any more children, 48% desired one or two and 16.2% desired three or more. Even though 153 (37.5%) of total sample did not desire any more children, more than half of those with a desire to limit births (58.2%) were not using FP at the time of the survey.

Most women in the sample (82.1%) reported discussing contraceptives with another person but only 48.3% discussed with their spouses or partners. Among the 104 users of modern methods, 78.8% reported spousal or partner awareness of their use. The injectables were the most popular contraceptives (82.6%). Those with ‘good knowledge’ of methods were the highest users of any method (70.9%). Contraceptive knowledge was strongly associated with use (p-value=0.0007) and health personnel were the most common source of information.

Common reasons for FP-use were: delay initiation of childbearing (44.1%), spacing (24.0%) and limiting (16.2%). Among non-current users, 60% had previously used a modern method but had stopped mainly due to fear of adverse effects (52.4%) and desire to have children (33.0%). Spousal and religious oppositions accounted for only 8.1% and 3.8% respectively. Among the 229 non-FP-users, 58.5% intended to use FP in the future. The most likely method would be an injectable (46.3%).

Knowledge contribution: FP-use in Hohoe is higher than nationally. Young, married women with one-two children were more often users than other women. The desire to delay initiation of childbirth, space and limit childbirth were important reasons for use while a great unmet need exists. The majority of women who had stopped FP reported fear of adverse effects. The appropriate provision of education and information, as well as the availability of a wide range of contraceptive options should be the targets for increasing contraceptive use in Hohoe district.

CO2: 2
Social Determinants for Sustained Use of Family Planning (FP)
Feven Tassew, Berissa Abdesta, Yalemshet Mekonnen, Yosef Alemu, Anna Summer, Barbara Pose
CARE International in Ethiopia, SRH Program Unit, Ethiopia; FevenT@care.org.et

Subtitile: Who is reached and who is left behind by traditional family planning programs (focussing on the couple)?

Background/Significance
CARE International is implementing Family Planning (FP) Programs in many countries in Africa with significant success in addressing unmet need.

The programs in Ethiopia – implemented since 1996 – rely on an effective approach which mobilizes the communities through the use of trained volunteers who adhere to the social norms of their culture.

Hypothesis or Intervention/Activity Tested
The uptake of family planning is not only influenced by service coverage and access, but is most importantly determined by social norms. If these social norms are not addressed, conventional community mobilization activities for family planning will exclude important subgroups, leaving them without access to family planning.

Methodology
A Social Analysis was conducted in two steps in the West Haraghe project area in Ethiopia to identify the gaps of the currently implemented Family Planning Program. To start, the project staff explored their own biases and behavior in regard to acceptable and unacceptable behavior regarding family planning, gender equity and rights approach.

The second step was the actual situation analysis done by the staff in the community itself.

Data
The data shows three major barriers related to

Health Service Provision→

Religious Norms→

Culture and Tradition→

Findings
FP program activities traditionally focus on improved access to FP service, hence targeting providers and couples. The effects of religious and social norms on gender roles not only influence each other, but also have a strong impact on family planning uptake as they determine stigma and discrimination of users.
Health Service Provision

1) Although contraceptives are available, the method mix available is often limited.
Lack of communication about the side effects of contraception often perpetuates the spread of rumors.

1) The primary target group for contraceptives are women, hence men are not encouraged to support their wives i.e. by reminding them to take the daily pill.
2) Health service providers do not proactively reach out to marginalized groups as widows, sex workers and adolescents to facilitate their access to FP.

Religious Determination

1) According to religious norms, sex is only acceptable in the context of marriage; hence Family Planning can only take place within the couple.
2) Although some passages in the Bible and the Koran refer to limiting family size for economic reason, there is an underlying fear that Family Planning is hindering God to bless you with children according to his plan. As a result, limiting the number of children is viewed as questioning God’s capacity to feed his creation.

Culture and Tradition

1) There is no open discussion about sexuality in the society and more importantly in the family.
2) Premarital sex, prostitution and adultery are taboo – as a consequence these behaviors are a sort of “blind spot” for the society: what is not happening does not need Family Planning. Therefore, adolescents, sex workers and widows have no access to Family Planning or they need to access them in secret to avoid stigma and discrimination.
3) Children are highly valued in society for status and are needed in the workforce: “the more the better”. Women with only 2-3 children might be regarded as infertile.
4) Women use high numbers of children to keep their husbands from taking another wife (polygamy) because economic resources become scarce.
5) Family Planning in wedlock is allowed under certain conditions; while economic reasons are accepted to justify the use of FP, the health of the mother is not.
6) Although marriage age according to Federal constitution stands at 18 years, many women in Haraghe are married much earlier. Marriage and childbearing leads to dropout from school, however delay of the first child using FP to finish educational goals is currently unacceptable in the Haraghe culture.

Knowledge Contribution or Lessons Learned

Addressing social norms is of paramount importance to increasing FP use beyond the conventional focus on the married couple:

1. To address the social determinants of FP uptake in the community, project staff need not only be equipped with facilitation skills to challenge communities, but perhaps more importantly project staff need to be confronted with their own biases to have a chance to transform in their own personal lives. This will make them real models.
2. FP interventions must overcome the common exclusion of men, youth, people living HIV/AIDS, and single women and men.
3. Elders, religious leaders and traditional healers must be included in FP discussions and, wherever possible, be encouraged to challenge their communities.
4. Other sectors such as agriculture should promote FP to address the economic burden of big families.
5. Likewise, community-based institutions such as savings groups or women’s associations should be included in reflections on community norms of FP utilization.
6. Community reproductive health volunteers need training beyond knowledge of FP methods on how to address social barriers to access.
7. Radio or other media could be used to challenge communities on social determinants.

CO2: 3

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

Caroline Mackenzie1, Katherine Tumlinson2, Marsden Solomon3, Rick Homan1, Kirsten Kruger2, Susan Igras1, Abdikadir Ore4, Abdullahi Mahat Daud4, Fatuma Iman5, David Adriaanse6

1Family Health International, Kenya; 2Family Health International, USA; 3Georgetown University, USA; 4APHIA II North Eastern, Kenya; 5Ministry of Public Health and Sanitation, Kenya; cmackenzie@fhi.org

Background

Social and cultural resistance to modern family planning (FP) methods accounts for approximately 1/3 of modern method discontinuation and up to 40% of the reasons for non-use of FP in Kenya where nearly 25% of women have an unmet need for FP. Natural methods of family planning offer a promising solution to unmet need and the Standard Days Method (SDM) has been promoted as a natural FP method that can overcome many social, cultural and religious barriers to FP use.

This presentation reports on lessons learned from a pilot introduction of the SDM in the rural semi-arid district of Ijara in North Eastern Province (NEP), Kenya. The majority of the population in this region are influenced by Islamic religion and Somali cultural practices. The contraceptive prevalence rate in NEP is less than 1%, and the total fertility rate is 8.1.

Activity tested

If the SDM is introduced to a region with a history of very low contraceptive uptake, who accepts the method, and what were they doing before?

Methodology

In 2008, a situation analysis was conducted, to assess the acceptability of introducing the SDM into the national FP method mix. 125 qualitative interviews were conducted with community members, service providers, and policy and program managers from three provinces. Relevant policies, guidelines and training materials were also reviewed. Results indicated that the SDM was acceptable among many, especially among respondents from NEP. These results were discussed at a national stakeholders’ meeting, which recommended the implementation of a pilot introduction of the method, starting with Ijara district of NEP. Before the pilot, religious leaders from Ijara district were educated on the method and the concept of healthy birth spacing, and they in turn sensitized the community on the method. Seven providers from 6 health facilities in the district were trained on SDM service provision and asked to complete a short client background card for each client accepting CycleBeads from January to June 2009. This card aims to document demographic data and FP history of clients.
accepting the SDM. In April 2009, face-to-face interviews were conducted with service providers to gather their experiences and opinions towards providing the service.

Findings
Between January and mid-May 2009, 123 SDM acceptor background cards from five health facilities have been received. To date, data from the SDM acceptor background cards indicate that 88.6% (n=109) of them had never used a FP method before. Of the 14 clients who had ever used a FP method before but desired to switch to the SDM, six of them said that they were doing so because the former method had undesirable side effects. Among all acceptors (n=123), the main reasons given for accepting to use the SDM were: does not affect health (40.5%); religious reasons (33.9%); and does not have side effects (31.4%).

Providers reported that compared to other FP methods, this method was acceptable to most clients because, being natural, non-intrusive and without hormones, it was culturally and religiously acceptable. Providers reported that the challenges they faced during service provision of the SDM included language barriers, general opposition to FP methods, low male involvement and low awareness of the method at the community level.

Lessons Learned
Training service providers to introduce the SDM into the available method mix in public health facilities in NEP resulted in increased uptake of natural FP and attracted many new FP users. Few women switched from more effective hormonal methods and those that did reported that they were not satisfied with their previous method. The SDM is highly acceptable in this setting but scale-up to other areas, particularly those under Islamic influence, will require strategic buy-in of religious leaders, community sensitization, male involvement and dedicated resources for information, education and communication materials, and commodity supplies. In addition, gaps in service provision need to be addressed through regular and continuous supportive supervision and mentorship.

By offering an FP method that is socially and culturally acceptable, women who otherwise would not use a FP method or are likely to discontinue FP use now have an option for limiting or spacing births.

C02: 4

Variations in Unmet Need for Contraception over the Lifecourse
Susan M. Lee-Rile, Anju Malhotra
International Center for Research on Women, United States of America; slereife@icrw.org

Background/Significance
Unmet need for contraception and its scope are an increasingly important concern around the world. Widespread trends toward declining family size preferences mean that more and more women want smaller families, but many do not have access to the contraceptive and abortion services that enable them to achieve their goal. Despite significant programmatic efforts, levels of unwanted and mistimed pregnancy remain high in both developed and developing countries. Moreover, in light of these changing preferences and declining fertility levels worldwide, child spacing is becoming a more pressing need for women in developing countries. Addressing unmet need thus requires a more nuanced approach, one that accurately identifies women with unmet need and the intensity of that need, recognizes that the nature and extent of women’s unmet need may change over the lifecourse, and that women’s ability and willingness to use family planning may also vary.

The definition and measurement of unmet need has received considerable attention, and significant effort has gone into improving its measurement by better taking into account women's own, self-defined needs for contraception. However, even with the fine-tuning that has occurred, traditional cross-sectional measures are not as useful as they could be for program planning because they cannot capture the extent to which women have experienced unmet need over their reproductive lifecourse, nor can they account for the possibility that accumulated experiences with unmet need over the lifecourse may in fact influence women’s subsequent contraceptive use. Traditional measures would not, for example, distinguish an older woman who wants to stop childbearing but who is discouraged from seeking contraception because of a long history of unmet need, related to contraceptive side effects or other barriers to use, from a younger woman who has not previously wanted to delay/end childbearing but who wants to delay the birth of her second child. The differing nature of their unmet need and their barriers to use would require very different programmatic responses, but traditional snapshot measures would provide little guidance in shaping those responses. Understanding the dynamic nature and intensity of unmet need over women’s reproductive lifecourse, and the varying reasons underlying their unmet need, would provide critical guidance to policymakers and program designers.

Research Questions
This paper examines the extent and dynamics of unmet need over the lifecourse, using a unique dataset of Indian women that allows us to trace women’s experiences at different lifestages. In particular, we investigate: 1) how and to what extent the level of unmet need varies across the lifecourse; 2) what proportion of women’s reproductive lifecourse is spent with unmet need for contraception; and 3) how do the reasons given for non-use of contraception vary over the lifecourse?

Methodology
The data come from interviews conducted in Madhya Pradesh, India in 2002 with 2,444 married women between ages 15-39 with at least one child. Data was collected using a narrative life history technique used to elicit details about pregnancy topics. Respondents were asked a series of questions about each pregnancy concerning fertility preferences, contraceptive use, and husband's preferences, as well as demographic and household information. This resulted in a dataset including information on 11,160 pregnancy intervals. In many cases, the survey traced respondents’ entire reproductive lives. The pregnancy-specific data allows us to measure lifecourse stage and to create cumulative measures of unmet need and potential determinants. Consequently, we can examine empirically the intensity and patterns of unmet need over the lifecourse. We use both descriptive and multivariate techniques to explore how unmet need varies by lifestages, to determine the proportion of intervals in which a woman experienced unmet need, and examine lifecourse variations in reasons provided for non-use of contraception and its determinants.

Findings
Preliminary analysis suggests that women experience significant levels of unmet need over the lifecourse, reflecting more extensive unmet need than traditional, cross-sectional measures. Women in this sample have typically experienced unmet need during multiple periods of their lives, indicating long-term exposure to the risk of unwanted and/or mistimed pregnancies and suggesting a significant potential impact on the quality of their lives. The analysis also demonstrates that there is considerable variation in the reasons women report to explain their unmet need, with lack of knowledge, opposition from husband and other family members, and other access impediments more predominant in the early stages of family formation and fears about side effects and health concerns more important in later stages.

Knowledge Contribution
These results will provide clear guidance to policymakers and program designers to better target efforts to reduce unmet need, increasing their ability to address the particular needs of women and the efficiency of resources spent to this end. These improvements would help individuals and couples to meet their reproductive health needs, help the country avoid the burden of excess fertility on the health system, and also help it to benefit from the demographic dividend.

C02: 5

Effects of economic status and family planning ideation on married women’s fertility intentions in Ghana and Kenya

Agbossi Amouzou, Stan Becker
Johns Hopkins Bloomberg School of Public Health, United States of America; aamouzou@jhsph.edu

Background: Fertility intentions have been shown to determine contraceptive behaviors and fertility in developing countries. Two main factors are usually at the center of the debate on causes of fertility decline: economic status and ideation factors. While it is recognized that these two factors affect fertility through adoption of contraception, it is not always clear which of the two has a prominent effect on contraceptive behaviors and ultimately on fertility. In this work our primary interest is to assess the joint and separate effects of economic status and family planning ideation on fertility intentions in Ghana and Kenya, two countries that were among the early adopters of family planning programs in Africa and where fertility has declined rapidly and then stalled in the past decade.

Data and methods: We used data from the 2003 demographic and health survey (DHS) in Ghana and Kenya. These surveys interviewed 5,691 and 8,195 women respectively and collected information on women’s intention to have a child or additional child and when they would like to have this child. Response to this question allowed classification of women in three groups: (1) women who want no more children; (2) women who want to delay their next childbearing for at least two years, and (3) the residual group composed women who want another child soon or who reported infecund. We fit a multinomial regression on this variable to assess the independent and joint effects of economic and ideation status on women’s fertility intentions. Economic status was operationalized through a wealth index computed from household assets using principal component analysis. Similarly, the ideation status was estimated as a composite index from psychosocial variables related to knowledge and discussion of family planning, attitude toward family planning, ideal family size, exposure to family planning messages and home visits by family planning workers. Principal component was also used to generate scores based on the first principal component. A test of exogeneity of the ideation index was conducted using a recursive bivariate probit model to ensure that the multinomial models are unaffected by endogeneity between ideation and fertility intentions. Given that the fertility is culturally valued in these two countries and married women with no children or with one child would desire to continue childbearing, we limited our analyses to married women with at least two children. Thus the analyses were based on 2720 and 3681 married women in Ghana and Kenya respectively.

Findings: Respectively 47% and 60% of married women with at least two children reported wanting no more children in Ghana and Kenya. Respectively 32% and 24% desired to delay childbearing. In both countries, ideation status was strongly and positively associated with women’s intention to stop or to delay childbearing after adjusting for economic status, women’s and husbands’ education, urban-rural residence, ethnic group and number of children living. In other words, women who are more exposed to family planning messages through media or interpersonal discussion or home visits by family planning workers are more likely to desire to stop or to delay childbearing, regardless of their economic status. The adjusted effects are stronger in Kenya where married women in the highest ideation quintile are ten times more likely to desire to stop childbearing and three times more likely to desire to delay childbearing than those in the lowest quintile. In Ghana the odds of desire to stop or to delay childbearing increased two-and-a-half in the adjusted model. The adjusted effects of economic status on the intention to stop childbearing are insignificant in Ghana, whether in presence of ideation status or not. However, economic status affected significantly the intention to delay childbearing after adjusting for the control variables. But unlike ideation, these effects are negative indicating that wealthiest women are less likely to desire to delay childbearing than the poorest women. The likelihood of this intention is reduced by 70% between the poorest and the richest women.

Different patterns were observed in Kenya where the adjusted effects of economic status on intention to stop childbearing were highly significant, especially when ideation status is not controlled for. There was a significant difference between the poorest and middle or upper quintiles with the odds-ratios increasing from 1.4 to 2.8. Unlike Ghana, economic status showed no significant adjusted effects on intention to delay childbearing.

Knowledge contribution: These findings demonstrate the necessity of continuous and even stronger consideration for family planning ideation factors in population programs that intend to generate demands for family planning. This is particularly important in Ghana where economic status did not appear to exert a strong independent effect of intention to limit family size. Outreach programs and social network interventions for family planning are such interventions that have shown positive effects on contraceptive behaviors and must be strengthened in both countries.

D02: Integrating FP and HIV Programs II

Time: Monday, 16 November 2009: 11:30am - 1:00pm

D02: 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

Grace Nagendi1, Charles Ngobi2, Betty Farrell3, Isaac Achwai1, Nalin Johri2, Henry Kakande4, Hannah Searing1, Laura Subramanian1
1Engender Health, Uganda; 2The AIDS Support Organization (TASO), Mbale, Uganda; 3EngenderHealth, New York, USA; gnagendi@engenderhealth.org

1. Background/Significance: HIV prevalence in Uganda is 6.7%, which translates to approximately 1 million people living with HIV (PLHIV). High unmet need for family planning services and low contraceptive use contribute to increased risk of unintended pregnancy among Ugandan women. Currently, 40% of married Ugandan women aged 15-49 have an unmet need for family planning, and only 24% are using a FP method. For PLHIV, unplanned pregnancies can lead to a potentially increased risk of mother-to-child transmission of HIV as well as maternal health and economic concerns. Many HIV-positive men and women are sexually active and need access to comprehensive reproductive health (RH) services to address their needs.

2. Research: Growing evidence suggests that PLHIV lack adequate access to these services, and health workers lack the knowledge and skills to support PLHIV in making informed contraceptive choices. Consequently, many of the 130,000 new infections in Uganda each year result from unintended pregnancies among PLHIV. There is a pressing need to develop effective programmatic models to address the FP/RH needs of PLHIV.

3. Program: EngenderHealth, through the ACQUIRE Project collaborated with The AIDS Support Organization (TASO) and the Ugandan Ministry of Health to pilot the integration of family planning into HIV care and treatment services at TASO/Mbale ART Center in eastern Uganda. The project was implemented from March 2006 to April 2007 and funded by USAID/Washington’s FP/HIV Integration Global Leadership Priority (GLP) team in the Office of Population.
DO2: Demand for Family Planning among women VCT clients: The need for Integration, Dessie town, Northeast Ethiopia

Dessalew Emaway Altaye1, Mesfin Addisse2, Yilma Meikamu2

1Engender Health, Ethiopia; 2Addis Ababa University School of Public Health; dessalew98@yahoo.com

1. Background/Significance -
Integrating family planning services with HIV/AIDS services such as Voluntary Counseling and testing (VCT) is imperative in preventing unintended pregnancy, reducing number of AIDS orphans, preventing vertical transmission of HIV and sexually transmitted infections including HIV/AIDS. Information lacks on the family planning needs of VCT clients. It is essential to determine the extent of demand and provision of family planning in VCT settings as well as the potential opportunities & challenges of integrating family planning services with VCT.

2. Research: State main question/hypothesis
Program: State intervention/activity tested
To assess the demand for family planning among VCT clients and the integration of family planning services with voluntary counseling and testing services.

3. Methodology (including location, setting, period, analysis approach)
A facility based cross-sectional study was carried out in VCT centers in Dessie town, Northeast Ethiopia between December, 2006 and February, 2007. The study participants were female VCT clients who are in reproductive age group. The study employed both quantitative and qualitative study methods. The data were entered, cleaned and analyzed using SPSS statistical soft ware version 11.

4. Data (if relevant)

5. Findings
Of the 422 female VCT clients participated in the study, 11.8% were counseled for family planning. VCT centers owned by NGOs were more likely to counsel their clients on family planning than governmental VCT centers: [AOR (95%CI) = 7.28 (2.07, 25.58)]. Great proportion of VCT clients (80%) want either to limit or to postpone child bearing. Among 166 sexually active clients 35% were current users of family planning methods and out of 384 non users of family planning methods 60% intended to use in the future. The unmet need for family planning among sexually active clients was 55%. The zero-status of the client was not significantly associated with the extent of family planning counseling and the level of unmet family planning need. Multivariate analysis showed that those who were in the age groups 15-19 and 20-24 years were more likely to have high unmet need for family planning as compared to those who were beyond 24 years: [AOR (95%CI)=6.46 (1.65, 25.33), and 5.46 (1.64, 18.20)], respectively. Ninety eight percent of clients and majority of counselors supported provision of family planning services at VCT centers.

6. Research: State knowledge contribution
Program: State lessons learned
Women coming for counseling and testing were not served for FP services even though they had huge unmet need. There were very level missed opportunities. Improving provision of family planning information and services at VCT centers and strengthening service linkages were recommended.

DO2: Service delivery characteristics associated with contraceptive use among youth clients in voluntary counseling and HIV testing clinics with integrated family planning services

Joy Noel Baumgartner1, Rose Otieno-Masaba2, Mark Weaver1, Thomas W. Grey1, Heidi Reynolds1

104
Background/Significance

Many clients seeking voluntary counseling and HIV testing (VCT) services in Kenya are youth, i.e., 24 years old and younger, and high levels of unmet contraceptive need among VCT clients have been documented. Previous studies have shown that youth seeking VCT services have HIV risk behaviors, but they are also at risk for unintended pregnancy. One strategy to address the dual contraception and HIV prevention needs of youth is through integrated contraceptive-HIV services. However, integration of contraceptive services in VCT services is such a new area that we do not yet understand the factors associated with family planning uptake among VCT clients, much less among youth clients. There is still a need to understand how the characteristics of services, such as services that are tailored to youth or integrated services, affect behavior, such as contraceptive uptake.

Kenya has at least two models of integrated VCT and family planning (FP) services that serve youth. General population VCT clinics have increasingly added family planning services to their scope of services for clients of all ages including youth. These general VCT clinics are usually co-located with other health services and many VCT providers have been trained to screen clients for unintended pregnancy risk, counsel on FP methods, provide some methods and refer for others, and refer for re-supplies and follow up. Meanwhile, youth clinics only serve youth of a designated age range, have providers who have been trained in youth friendly services, and provide both VCT and family planning on site.

Hypothesis or Intervention/Activity Tested

This descriptive cross-sectional and cohort study has the following study objectives:

1) To describe how the characteristics of facilities, available services, providers, and clients vary across a variety of FP-VCT integrated clinics that serve youth, and

2) Taking into account the characteristics of clients who seek VCT services, to determine what facility and provider level characteristics are associated with the following outcomes of interest: same day uptake or intention to use contraception after the VCT session, and contraceptive use three months after the VCT session among youth clients.

Methodology

Twenty study facilities were randomly selected from youth clinics offering VCT and FP (8 sites) and general population VCT clinics integrated with family planning services (12 sites) across Kenya in 2009. We conducted client exit interviews with female and male VCT clients ages 15-24 who were willing to be followed-up by phone or in person, provider interviews, and structured observations in each health facility at baseline. Follow-up interviews with clients are being conducted to assess contraceptive use three months after their VCT service.

Structural equation modeling (SEM), specifically a path analysis, is being utilized to test the relationships between client, provider, and clinic characteristics, program processes and outputs, and the two outcomes of interest. Two process/output indicators that measure what happened during the client-provider interaction (counseled on dual method use/dual protection and counseled on multiple modern methods) are included as intermediate variables in the SEM.

Client variables include relationship status, recent sexual activity and current contraceptive use. Provider variables include work experience, received training in FP-VCT integration and youth-friendly services, and knowledge and attitudes about family planning and integration. Facility variables include a number of created indices such as strength of integration, youth-friendliness, and quality of VCT. Prior to fitting the SEM, exploratory factor analyses and Cronbach’s alpha will be conducted to assess which items contribute significantly to each index.

Data/Findings

Initial descriptive findings show that a total of 388 youth clients aged 15-24 were interviewed at their VCT service visit (208 young women and 180 young men). Fifty providers were interviewed and 20 structured observations (one per facility) were conducted. Among all clients, 45% reported current contraceptive use (predominantly condoms), 42% reported that their VCT provider counseled them on pregnancy prevention methods, and 13% reported receiving a method that day but only 69% of those reported they were very likely to use that method. Only 15 providers reported being trained on FP-VCT integration and 33 reported training in youth-friendly services. Results from the SEM will show what facility and provider level characteristics are associated with same day uptake or intention to use contraception after the VCT session, and contraceptive use three months after the VCT session, controlling for client characteristics.

Knowledge contribution

This study contributes to the scant body of knowledge regarding the behavioral outcomes of services that offer family planning within VCT and what facility and provider characteristics influence adolescents’ contraceptive use. The study purposefully focused on service delivery factors that were amenable to change (e.g., quality of care, youth friendly services, integrated services). Thus, service characteristics associated with contraceptive uptake among youth VCT clients can inform programs about how to improve FP services for youth and ultimately respond to their dual reproductive health needs.

D02: 4

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

Lorrie Gavin, Galavotti Christine

US Centers for Disease Control, United States of America; lc6@cdc.gov

Background/Significance

The prevention of unintended pregnancies in HIV-infected women is one of the four strategies promoted by WHO (2002) to prevent mother to child transmission (PMTCT), and could be as effective a strategy as antiretroviral interventions (Sweat et al 2004). In addition to the many benefits to HIV-infected women and their families, it has been estimated that providing family planning services at HIV treatment sites could save almost $25 dollars for every dollar spent (Stover et al. 2004, as cited in Fleischman 2006).

Yet little is known about how a woman’s HIV status affects her desire for additional children and her sexual behavior/use of contraception. The limited body of existing research indicates that women’s reactions are mixed. Most studies have shown that some HIV-positive women continue to want to bear children. Other studies have shown that some HIV-positive women do not want more children, and have observed increased use of contraception, increased frequency of abortion and lower pregnancy rates after a woman learns her status. Still other studies have shown high rates of unintended pregnancies among HIV+ women, due to sexual violence, poor access to family planning services, fear of social stigma that might occur after disclosure of an HIV diagnosis, fear of the health effects of contraception, gender inequality, etc.
However, decision-making about childbearing is a highly complex process, which is influenced by biomedical, individual and social factors. A better understanding of these multiple influences is needed to design effective interventions.

This study contributes to existing research in several ways. First, it considers a wide range of individual and social influences on HIV+ women’s decision making regarding child-bearing and on sexual behavior. Further, it compares HIV+ to HIV- women. Third, it uses a national, population-based sample from a low-resource country in Africa.

Main Question/Hypothesis
1. Are HIV-positive women in Zimbabwe less likely to desire a future pregnancy than HIV-negative women?
2. What other factors are associated with a desire to have children in the future?

Data
The Zimbabwe Demographic and Health Survey 2005-2006 was used. The study included 8907 females women 15-49 years of age for whom HIV test results were available. Women who had been sterilized or declared infecund were excluded.

The dependent variable was a woman’s desire for any future pregnancy (yes/no). The primary independent variable was a biomedical condition, i.e., her HIV status. Other independent variables assessed individual influences on future pregnancy desire (age, education, marital status, parity and socio-economic status). Older women were more likely to want future pregnancy compared to women aged 15-19 years (e.g., the OR for women aged 35-39 years = 2.27, 95% CI=1.41-3.64). Women with a higher level of education were more likely to want a future pregnancy than women with no education (e.g., the OR for women with a secondary education = 3.76, 95% CI=2.27-6.24). Compared to women who were currently married, those who were never (OR=3.01, 95% CI=2.12-4.27) or formerly married (OR=4.05, 95% CI = 3.18-5.17) were more likely to want a future pregnancy. Women with more children were more likely to desire no future children than women without a child (e.g., the OR for women with 2 children = 18.1, 95% CI=11.2-29.3). There were no statistically significant associations between desire for a future pregnancy and a previous history of being tested, or with any of the hypothesized social influences.

Knowledge contribution
In this study, HIV-positive women in Zimbabwe were more likely than HIV-negative women to not want any more children. Efforts should be made to ensure they have ready access to family planning services, e.g., in VCT, PMTCT and ART treatment services. Future research should examine the role of HIV testing and social influences, especially their potential indirect (rather than direct) effect on desire for future pregnancy.

Word count: 742

DO2: 5
Increasing support for family planning as HIV prevention: identification of influential individuals and stakeholder perceptions

Tricia Petrune1, Sarah V Harlan1, Lipika Nanda1, Mukesh Janbandhu2, Elizabeth T Robinson1
1Family Health International, United States of America; 2Family Health International, India; tpetruney@fhi.org

Background
Preventing unintended pregnancies among HIV-positive women is one of four key elements of a comprehensive approach to preventing mother-to-child transmission (PMTCT) of HIV. Yet the vast majority of programs do not prioritize or operationalize this critical element within their respective components and family planning remains an underutilized yet effective prevention strategy. Further, targeted improvements need to be made to effectively meet the contraceptive needs of women and couples living with HIV. By applying social and behavioral sciences, and specifically a “target, tailor, and tip” approach, Family Health International is implementing an innovative project to target influential HIV stakeholders with a set of tailored messages in order to improve support for linking family planning and HIV/AIDS, and the use of voluntary contraception as an important PMTCT strategy. This three-pronged strategy is being applied in two distinct phases; the first encompasses the global arena and the second is focused within one of the largest and the highest HIV prevalent states in India, Andhra Pradesh.

Research & Methodology
Influential stakeholders were systematically identified using a criteria-based model. To develop targeted advocacy messages for the global stakeholders, 22 key informant interviews were conducted from the pool of more than 500 individuals identified from the international HIV/AIDS arena. Respondents were selected using mixed purposeful sampling. Through these interviews, we explored levels of knowledge of contraception for HIV prevention, and identified common obstacles to and facilitators of implementation of the strategy. Using the same stakeholder mapping methodology and informant selection criteria, between 20 and 30 stakeholder interviews will be conducted between June and August 2009 in Andhra Pradesh to develop tailored advocacy messages for key HIV/AIDS stakeholders in southern India. Qualitative analysis using a codebook approach is being applied to the set of interviews from each phase.

Findings
Overall, respondents from the first phase acknowledged the benefit of linking family planning (FP) and HIV programs, but identified major challenges to this becoming a reality, including separate funding streams that result in implementation of parallel programs. Other themes included political and cultural resistance to family planning, a lack of understanding about contraception for HIV prevention, insufficient published research on the effectiveness of linked or integrated FP/HIV services, a need for stronger policy support, and a need for provider training on meeting the contraceptive needs of HIV-infected women. These first phase findings will be complemented by the results from the second phase key informant interviews in Andhra Pradesh, and national versus international results will be compared and similarities and differences discussed.

Knowledge Contribution
A diverse set of individuals have regional or international influence in the field of HIV, and the challenge of fostering greater support for linking family planning with HIV/AIDS, meeting the contraceptive needs of women and couples living with HIV, and implementing contraception for HIV prevention is complex. Our preliminary findings affirm the existence of a multi-layered set of barriers that do not easily lend themselves to remedy. Conference participants will gain a better understanding of:

The perspectives of influential HIV/AIDS decision-makers with regard to the obstacles to effective integration, from an international angle and from within Andhra Pradesh.

How efforts to harness the diverse skills and decision-making authority of influential individuals – to launch strengthened education, advocacy, communication and research efforts, as well as to promote fundamental changes in funding mechanisms and policy structures – are necessary to affect measurable change.

The applicability of this social science methodology to other family planning objectives.

### E02: Contraceptive Technology II

**Time:** Monday, 16 November 2009: 11:30am - 1:00pm

#### E02: 1

**Fertility Awareness-based Methods and Gender**

Irit Sinai, Sujata Bijou

Georgetown University, Institute for Reproductive Health, United States of America; Sinaii@georgetown.edu

Knowledge contribution

**Understand how integrating fertility awareness-based methods of family planning into services can contribute to gender equity and women empowerment.**

**Background**

Promoting gender equality and empowering women is one of the Millennium Development Goals. A cornerstone of woman’s empowerment is the ability to control her own fertility. Data from several studies were examined to determine if integrating Fertility Awareness-based Methods (FAM) into family planning services may promote gender equity through increasing women’s knowledge and control of their fertility and improving partner communication and cooperation.

**Activities tested**

FAM are methods that help women identify their fertile window – the days each cycle when they are most likely to become pregnant if they have unprotected sex. Couples using FAM avoid unprotected intercourse on these days to prevent pregnancy. These methods require partner communication, as the men need to know that the woman identifies a day as fertile; and partner cooperation – the couple need to agree not to have unprotected sex on fertile days. However there is some concern that using FAM may reinforce existing stereotypes of male dominated, sexually submissive women.

To explore that effect of FAM use on gender equity we examine data from a number of studies of users of two types of FAM: Standard Days Method and TwoDay Method. The Standard Days Method identify as fertile days 8-19 of the cycle for all users. It works best for women with cycles that usually range 26-32 days. The TwoDay Method identify as fertile days in which the woman noted vaginal secretions (of any type) that day or the day before.

**Methodology and data**

First, we use data collected in 16 settings in seven countries in Asia, Latin America and Africa, where the Standard Days Method was introduced into family planning services. The effect of method use on couple relationship and women’s autonomy were assessed through quarterly interviews with 2,422 users followed up for at least two years of method use. Interviews with male users and focus group discussions were also held.

In addition, we use data from a study that compared two visual aids associated with the Standard Days Method in Guatemala, and a study that tested a quick start approach to offering the TwoDay Method in Peru. Both studies followed women for up to seven cycles of method use, and included a series of questions about couple decision making and couple communication, including respondents’ perceptions of communication with their partners, their right to refuse sexual activity, their partners’ right to beat them, and decision-making within the household. These questions were asked at admission to the study, and again at exit, allowing us to measure change associated with method use, using Pulerwitz scales.

**Findings**

Results suggest that using FAM does promote gender equity through improvements in couple communication and cooperation, as the following sample results illustrate. In the presentation we will discuss results fully.

Control own fertility -- Many Standard Days Method users are first time users of family planning (59% in India, 94% in Rwanda, and 45.2% in Benin). Using the Standard Days Method gives many women who previously did not use family planning the ability to control their fertility because it is a simple, inexpensive, and accessible method, which is compatible with cultural and religious beliefs.

Communication -- In one of the introduction studies in India, 93% of women reported increased communication, affection, and improved ability to discuss sex. As one woman said, "On the white bed days I simply say no. Now, I am no longer afraid to say no to him". Many Indian women also reported enhanced sexual relationships. In Rwanda, the majority of couples reported that the Standard Days Method encourages an atmosphere conducive to dialogue and confidence between partners. A male Standard Days Method user in Rwanda said, "It makes dialogue become more intimate".

Cooperation -- In Benin, about 80% of users said the Standard Days Method involves men as supportive partners in using the method. For the remainder 20% the partner was not directly involved in method use, but there was no negative connotation. Partner participation was even higher in India. In the Guatemala study of the Standard Days method we found an increase between admission and exit interviews in the communication and right-to-avoid-sex scores. The TwoDay study in Peru shows similar increases.

These results suggest that offering FAM not only expands family planning choice, but also increases women’s empowerment thorough increased knowledge and control of fertility and improved couple communication and cooperation.

### E02: 2

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

Markus J Steiner1, Diane Luo2, Aida M Cancel3, David Jenkins4, David Asante5, Heather Vahdat4, Haizhen Meng6

1 - 4 - Centre for Reproductive Health, University of Edinburgh, United Kingdom
5 - School of Public Health, Georgia State University, United States of America
6 - Department of International Relations and Diplomacy, National University of Singapore, Singapore

**Abstract**

Contraceptive implants are the third most used contraceptive method worldwide, after oral contraceptives and condoms. However, demand far exceeds availability: 180 million women are in need. The Health and Deterministic Impact of the Contraceptive Regime (HDIR) contraceptive implant programme of the Population Council was implemented to address the demand for implants in Côte d'Ivoire and Bangladesh. The programme demonstrated that a government health system can be successfully integrated with the implant programme, and that a low-cost subcutaneous contraceptive implant can be delivered to a previously marginalized population.
Contraceptive implants are a highly effective and safe contraceptive method that also is acceptable to women worldwide. However, the high cost of this commodity has been a major drawback in ensuring its availability in many countries and is one of the main reasons that its use is not widespread in resource constrained countries.

Shanghai Dahua Pharmaceutical (Dahua) manufactures Sino-implant (II), a contraceptive implant that is available at more than 60% lower cost than other contraceptive implants being procured by international donors. The product, marketed as Zarin in much of Africa is made of two thin, flexible silicone rods, each containing 75 mg levonorgestrel and is currently marketed with a four-year duration of use. Eleven published clinical trials, with about 20,000 women followed for up to seven years, demonstrate that Sino-implant (II) is safe and effective with an annual pregnancy rate of less than one percent. To date, over 7 million units of Sino-implant (II) have been distributed in China and in Indonesia.

The introduction of Sino-implant (II) and its lower cost has sparked excitement in many developing countries where the demand for this method outstrips supply. Substantial cost savings can be realized through the provision of Sino-implant (II) in resource-constrained settings.

Methodology

A strategy for the successful introduction and registration activities of Sino-implant (II) was developed that includes activities in three key areas:

1. Monitoring the production quality of Sino-implant (II)
2. Facilitating regulatory approval in resource constrained countries
3. Coordinating successful introduction and scale-up activities

Findings

1) Monitoring the production quality of Sino-implant (II). Since 2006, Family Health International (FHI) led the efforts of evaluating the quality of Sino-implant (II) and the manufacturing practices with the goal of providing assurance that Sino-implant (II) meets strict international regulatory standards. The quality assurance evaluation for the first year of this project verified that Dahua is capable of producing an implant that meets international quality standards. This evaluation and monitoring program will continue for the next five years to provide continued assurance of the quality of Sino-implant (II) and includes lot release testing of all commercial lots shipped as part of this initiative.

2) Facilitating regulatory approval in resource constrained countries. In 2007, FHI signed an agreement to coordinate worldwide registrations. A business model was developed whereby FHI facilitates the negotiation of six-year exclusive distribution contracts between Dahua and prospective distribution partners; and FHI negotiates public sector pricing agreements. Through this business model, distributors will develop sustainable product revenue through the private sector, while guaranteeing a reasonable price for the public and nonprofit sectors. In return, distribution partners take the lead in country registration of Sino-implant (II). The Sino-implant (II) business model generated wide interest from prospective distribution partners, both from the public and private sectors. Sino-implant (II) was successfully registered in Kenya in August 2008 and in Sierra Leone in October 2008, under the tradename Zarin®. In coordination with partners, additional product dossiers have been submitted for drug regulatory authority review in eight countries (Burundi, Ethiopia, Ghana, Madagascar, Malawi, Rwanda, Uganda and Tanzania); and product dossiers are being prepared for submission in nine additional countries (Bolivia, Burkina Faso, Colombia, the Dominican Republic, Mali, Nigeria, Pakistan, Zambia and Zimbabwe). Activities associated with WHO prequalification are ongoing.

3) Coordinating successful introduction and scale-up activities. FHI and partners are committed to introduce Sino-implant (II) only in countries where infrastructure is adequate for successful and safe scale-up. Evaluations of the infrastructure are being conducted in collaboration with stakeholders and service delivery groups in each country. Educational materials are being updated, and a partnership with Knowledge for Health (K4H) is being established to disseminate this information via a website dedicated to implants.

Knowledge Contribution

Introducing Sino-implant (II) into programs in a well-coordinated manner leads to substantial cost-savings for governments and donors. Through an initial investment of one million US dollars, to provide assurance of the quality of Sino-implant (II) and to conduct registration and introduction activities, orders in the first four months of 2009 already achieved an estimated cost savings of US$1.4 million.

EO2: 3

Three Female Condoms: Which One Do South African Women Prefer?

Carol Joanis1, Mags Bekinska2, Jenni Smit2, Catherine Hart2, Katie Tweedy2

1Family Health International, United States of America; 2Reproductive Health and HIV Research Unit, Witwatersrand University, South Africa; cjoanis@fhi.org

Background/Significance:

Providing women in developing countries with female condoms (FCs) for pregnancy and HIV prevention has been a high priority for USAID and other donors. The Reality® female condom (now known as the FC1) was approved by the United States Food and Drug Association (US FDA) in 1993. Although FC1 has been marketed worldwide for 15 years, its distribution has been hampered by a unit price that is 20 times that of the male condom and acceptability issues that slowed uptake. The goal of USAID’s female-condom initiative is to help develop and bring to market lower cost female condoms that are equally or more acceptable and function at an equivalent level to the FC1. In this study, three female condoms were evaluated. They are: the FC2 (Female Health Company) recently approved by the FDA, the Reddy 6 (also called V-Amour) by Medtech Products, Ltd. and available in several African countries, and the PATH Woman’s Condom (a prototype in development) by the Program for Appropriate Technology in Health (PATH).

Hypothesis or Intervention/Activity Tested:

The purpose of this research study was to gather detailed information on comparative preference, acceptability and function for each of the female condom types. The primary endpoint was the determination of which of the three tested female condoms was preferred among study participants.

Methodology:
The study was conducted amongst 180 women at the Commercial City Clinic in Durban, South Africa. The research was carried out by the Reproductive Health and HIV Research Unit (RHRU) of Witwatersrand University from June 2007 to April 2008. This research was a prospective, cross-over study of product preference, acceptability, and function of three FC designs to determine which (if any) was the preferred device. The study was conducted in three distinct parts. Part 1 utilized a randomized crossover design and familiarized each participant with the use and characteristics of each of the three FC types. In Part 2, a ‘simulated market’ was created in order to determine an unbiased, free choice preference for a particular FC type. In-depth interviews were conducted in Part 3 and were used to elicit detailed reasons for participants’ selection/preference for specific FC types used in Parts 1 and 2. Each part was conducted concurrently, with women progressing voluntarily into subsequent phases of study. The primary preference analysis utilized a two degree of freedom chi-square test and was computed to compare the product preference probabilities across the three condom types. Condom performance (function) was measured using frequencies, percentages and 95% CI around percentages for each type of condom.

Findings:
The primary preference analysis showed a statistically significant difference in the preference probabilities among the three condom types, three pair-wise comparisons (PATH WC vs FC2; PATH WC vs. Reddy 6, and FC2 vs. Reddy 6) were performed using data from the subset of participants who preferred one of the types of FCs being compared. The participants clearly preferred the PATH WC and FC2 condoms over the Reddy 6 (p < .0001) and the PATH WC over the FC2 (p = .0007). Overall, out of 2423 condoms opened and 2376 condoms used all functionality problems such as breakage and invagination occurred in less than 2% of the devices. There were no significant differences among the FC types as regards functional performance. Ordinal acceptability outcomes (range 1 thru 5, disliked very much to like very much, respectively) were compared across the three condom types. Of eight condom comparisons, five were statistically significant: feel/sensation (p=0.0140); amount lubricant (p < .0001); appearance (p=0.0144); ease of use (p < .0001); and, fit (p=0.0082). The participants thought that the PATH WC was better than Reddy 6 in terms of feel, worse than both FC2 and Reddy 6 as regards lubrication volume, and better than FC2 and Reddy 6 in terms of appearance, ease of use and overall fit.

Knowledge Contribution or Lesson Learned:
Results showed that all women preferred one of the condom types and confirms the premise that if a range of options/choices are provided, couples may be more likely to select and use the method. These results could have important public health impact and provide women with additional options for contraception and STI prevention. The public sector price of FC1 is much higher than most developing country programs and individuals can support. By developing less expensive FC designs, comparing their acceptability and determining women’s preferences for each type, donor agencies may be able to purchase more devices and expand distribution networks which would improve access and availability of these devices. At present, FC2 and V-Amour are less expensive than the FC1. It is anticipated that the PATH WC will be comparably priced when marketed.

E02: 4
Pattern of Vaginitis Among Intra-uterine Contraceptive Device Users In Ibadan, South- Western Nigeria
Stella-Maris Ngozi Okonkwo, Michael Abiola Okunlola, Adebawale Abimbola Olutayo, Akinlade Olaawumi Adeleke, Oladosu Akani Ojengbede
University College Hospital, Ibadan, Nigeria; ellesfashions@yahoo.com

BACKGROUND/SIGNIFICANCE
The intrauterine contraceptive device is the most widely used reversible method of family planning worldwide. In Nigeria as well as the family planning clinic of University College Hospital, Ibadan, south western Nigeria it is the used preferred method by clients. IUCD-associated vaginal discharge is a documented reason for its discontinuation and is said to occur four-fold more commonly in users than non-users. Its aetiology differs among family planning clinics. This study aims to investigate its pattern and aetiology in south-western Nigeria. Results obtained may provide a new policy direction in its management so as to ensure continued use of the IUD among acceptors.

HYPOTHESIS TESTED: nil

METHODOLOGY: A prospective study of a cohort of IUD users presenting with vaginitis at the family planning clinic of the University College Hospital, Ibadan between 10th of October, 2008 and 19th of May 2009. The study was explained to them, informed consent obtained. High Vaginal Swabs were taken from the clients for microbiology, culture and sensitivity and their results retrieved.

DATA: A structured format was used to obtain data on their socio-dermographic characteristics. Results of microbiological studies and treatment was entered into the structured format. Results were analysed using SPSS 15(Statistical Package for Social Sciences).

FINDINGS/MAJOR OUTCOMES: The mean (+/- SD) age of the clients was 39.4 +/- 5.4 years and mean parity was 5.1 +/- 0.8. All the women were married. 56% were Christians and 44% were of the Islamic religion. 57% were at least secondary education. The CuT 380A IUD was used in all the cases. Duration of IUD use was less than a year in 40% (4users), 1-3 years in 10% (2 users), above 3years in 50%(10users) The mean duration of IUD use was 31.1 +/- 21 months or 2.6 years only.

All the clients complained of abnormal vaginal discharge which was either copious watery or foul smelling. 35%(7) of the IUD users complained of pruritus vulvae while 10%(2) complained of lower abdominal pain in addition to abnormal vaginal discharge. 6(30%) clients had recurrent discharge.

Yeast cells were identified on wet preparation in 30%(6) of IUD users. no trichonomas vaginalis was seen. Gram stain yielded mainly coccioid gram positive bacteria. Culture yielded Gdarenella vaginalis and anaerobic rods in 60%(12) and Candida albicans in 30%(6) of cases.

There was an association between age above 40years,increasing duration of IUD use and a positive culture of candidiasis which was not statistical significant.p<0.05) Concerning treatment 20% were treated for candidiasis either empirically or following retrieval of results, 10% (with abdominal pain) were referred to the gynaecological emergency unit, 20% were lost to follow up while 50% had oral metronidazole.

LESSONS LEARNED/KNOWLEDGE CONTRIBUTION: Vaginitis among IUD users appears to be more common within the 1st year of use and after three years of use. Candida albicans is an important aetiological factor south western Nigeria. Persistence of the discharge is a documented reason for discontinuation of IUD which may further increase levels of unmet contraceptive need. Periodic empirical treatment for candidiasis and oral metronidazole is suggested. This may help reduce the frequency of vaginitis and distress caused to IUD users and may ensure its continued use.

E02: 5
Expanding Contraceptive Options Through Incremental Improvement in Existing Technology and Developing Totally New Methods
Jeff Spieler
USAID, United States of America; jspieler@usaid.gov
(Alternative title - Contraceptive R&D – What’s New, What’s Around the Corner and What Still Remains to be Developed?)
1. Background and Significance – While not perfect, existing contraceptive methods have had tremendous impact in reducing TFR and maternal mortality by preventing unintended pregnancy. New contraceptive technology has an important role to play in expanding options, increasing CPR and further reducing fertility.

2. Hypothesis - Some of the current unmet need for family planning, estimated at 200 million women, and some of the relatively high rates of discontinuation of some current methods, estimated at up to 50% in 6 months, can be resolved, in part, with better and new contraceptive methods.

3. Methodology
The presentation will provide an educational and entertaining review, with some samples, of several new contraceptive methods that will be available within the next 2-5 years, and a description of a range of other methods that would have immediate application in clinic-based and community- based programs should they be developed.

4. Data
For each method to be presented, information will be provide on its advantages and disadvantages in comparison with current methods in the same class.

5. Findings
The highest priority in family planning is to:

5.1 Make all existing methods available and accessible to all women and men who want to prevent unintended pregnancy, and ensure commodity security;

5.2 Create demand for family planning where demand is constrained;

5.3 Make incremental improvements in existing methods to render the methods less expensive, more effective, safer, easier to provide and use, and more acceptable to providers and users; and

5.4 Develop new methods that would have immediate application in low resource settings.

The presentation will provide several examples of products that represent incremental improvements in existing technology such as the new 1-year combined progestin-estrogen vaginal ring developed by the Population Council and the one-size fits most Silcs Diaphragm developed by PATH and CONRAD that holds promise to be a dual protection method. Improvements in implants, like the Sino-Implant (II), and Depo-subQ Provera 104 in Unject will only be mentioned as these methods will be presented by others submitting abstracts. The presentation will also provide several examples of new methods, still to be developed, and that would have immediate application such as non-surgical methods of male and female sterilization, biodegradable implants, a single method that prevents both unintended pregnancy and HIV/STIs, and non-hormonal oral contraceptives.

6. Knowledge Contribution or Lesson Learned
The participants will have a good understanding of the importance of expanding contraceptive options and be able to cite specific examples of several new methods that represent incremental improvements in current contraceptive technology, and several examples of totally new contraceptive methods that would have immediate application in clinic-based and community-based programs once developed and delivered.

F02: Promoting FP through Digital, Mobile and Wireless Technologies

Time: Monday, 16 November 2009: 11:30am - 1:00pm

F02: 1
Mobile and Wireless Technologies in Support of Family Planning Programs: Present and Future Solutions for Faster Reporting without Sacrificing Data Quality

David Charles Cantor1, Virginia Lamprecht2
1ICF Macro, United States of America; 2USAID/GH/PRH/SDI; David.C.Cantor@macrointernational.com

1. Background/Significance
The advancement and proliferation of ICT (information and communication technologies) including the exponential growth in cell phone use and GPRS (General Packet Radio Service) for texting data in Sub-Saharan Africa and other parts of the world presents new opportunities to streamline the process of data collection, data reporting and results dissemination.

Five years ago in August 2004, the feasibility and cost-effectiveness of using Windows mobile Pocket PCs for a baseline family planning survey was developed and tested in rural Albania by the authors in conjunction with the Albanian Red Cross. This field test also looked at the cost effectiveness of electronic versus paper data collection and comparisons of data quality.

This session will focus on factors and trends since the implementation of this 2004 survey that influence the use of mobile and wireless devices to implement small area family planning and other health surveys in low resource settings. The session will also feature a live demonstration of mobile data capture of family planning data, transmission of data and real time monitoring of that data over the web.

2. Program Intervention/activity tested:
In the five years since the authors developed the family planning survey instrument, they have also developed related mobile data tools for facility surveys, data quality audits and data checklists in other countries. At the same time stand-alone PDAs have grown less common with a move towards integrated Smartphones, which combine many of the benefits of PDAs with cell phone technology. 50% of the world now has cell phones and in Sub-Saharan Africa alone there are over 300 million users; and many users are routinely sending text messages. Integrated Smartphone’s are able to collect and transmit data directly to a database with benefits such as:

- Faster turnaround time
- Transmission of data through without a web connection
- Two-way transmission allows program changes to be dispatched back to each Smartphone user already in the field
- Ongoing monitoring activities can be tracked in real time
- Transport issues (rugged Terrain, bad roads, political boundaries, etc.) can be avoided
Mobile operators will invest $50 billion in Sub-Saharan Africa over the next 5 years which will result in 90% potential coverage—making the likelihood high of using cell phones for routine data collection.

3. Methodology

A field test of a family planning survey using pocket PCs versus the paper version of the same survey was conducted in 3 districts in Northern Albania in August 2004. The baseline survey targeted 660 respondents residing in each of the districts. The study design featured a 30-cluster sample (10 clusters in each district) using three teams and 3 Pocket PC per team, collecting data over 6 days. Using inexpensive, off-the-shelf Pocket PC software the data entry functionality included:

- Sampling Information preloaded and imported from Excel spreadsheets
- Family Planning Program indicators were calculated immediately from multiple questionnaire input
- GPS enabled PDAs can capture GIS coordinates directly into the mobile data form
- Post interview HTML data check template at the end of the interview used for data quality

4. Data

The FP questionnaire used in Albania had 11 sections and 215 fields. Interviews took approximately 15-35 minutes to complete. Range, field control, and data consistency checks were enforced at the point of data entry. This ensured immediate feedback to the enumerator to ensure a correctly completed questionnaire.

A clean dataset (with calculated indicators) was available within one week of data collection. Considerable time and money were saved due to the elimination of costs related to paper, printing, and manual data cleaning. Additionally:

- The response rate and data quality between paper and electronic versions was comparable
- Supervisors and interviewers were enthusiastic
- Users not intimidated by the technology
- Elimination of office entry from paper saved time and money

5. Findings

Based upon the author’s experiences with mobile data collection, and the proliferation of wireless data devices and services in low resource settings, an opportunity is presented for developing an effective model for more efficient routine and small area survey reporting without sacrificing data quality. While text messaging from a cell phone to a database without a form has been used to transmit simple family planning and health data in certain cases, routine and survey data collection implemented on a mobile device requires a more tightly controlled entry form to ensure completeness and data integrity.

(6) Knowledge Contribution or Lessons Learned

The authors will demonstrate the model of how data can be collected on and transmitted from a mobile device using the same telecommunication protocols used by text messaging to a central database, and the subsequent viewing of that data over the web.

F02: 2

Family planning via mobile phones: Proof-of-concept testing

Katherine Sarah Lavoie1, Victoria H Jennings2, Meredith Puleio3, Priya Jha1,4, Rebeca I Lundgren1

1Georgetown University, United States of America; 2Institute for Reproductive Health, India; ksl24@georgetown.edu

1. Background/Significance

Mobile phones are the fastest-growing technology in the developing world, with more than two thirds of the world’s 4.1 billion mobile phone subscribers living in developing countries. The vast majority of subscribers are women and men of reproductive age. Mobile messaging services are extremely popular and growing, with mobile phone users sending over two trillion messages annually worldwide. Short Message Service (SMS) technology has been used to provide health-related information directly to users (e.g., One World’s Mobile4Good in Kenya) and to serve as reminders to people needing to take medicines at regular intervals (e.g., SIMplicity® Medication Adherence System in South Africa and Botswana). In light of the high unmet need for family planning and reproductive health information, there is the significant potential to help women avoid pregnancy and improve their reproductive health by providing them with timely, actionable, personalized information through Short Message Service (SMS).

To fulfill this potential, Georgetown University’s Institute for Reproductive Health (IRH) has developed a mobile application called CycleTel™ that pioneers supplying a family planning method—the Standard Days Method® (SDM)—directly to a user’s cell phone. The Standard Days Method is a fertility awareness-based method that requires the user to avoid unprotected sex during days 8-19 of her menstrual cycle. The method is appropriate for women with cycles 26-32 days long and is typically used with a visual tool called CycleBeads®. It is more than 95% effective in avoiding unplanned pregnancy and is recognized as an “evidence-based practice” by the World Health Organization. CycleTel provides the woman with information about her daily fertility status according to the SDM and advice on avoiding or achieving pregnancy.

2. Hypothesis

Our ultimate goal is to determine whether offering CycleTel expands access to family planning. A study was conducted to assess the acceptability and feasibility of delivering the SDM using the CycleTel application and to refine the application’s specifications. The study seeks to understand cell phone use patterns; the appropriate content, frequency and timing of the messages that support SDM use; whether women would like their male partner to participate in sending or receiving text messages; men’s interest in participating in CycleTel and receiving SMS messages; and how to reach potential users.

3. Methodology

The CycleTel Proof-of-Concept study has three components: focus group discussions, cognitive interviews, and a manual testing phase that includes interviews with users. This presentation gives results from focus group discussions and cognitive interviews that provided input into the application. First, focus group discussions were conducted with groups of women and men in the city of Lucknow, India, in order to understand cell phone ownership and use patterns, explore interest in the SDM and CycleTel among women and men, and to get input from potential users into preferences for message frequency and content. Utilizing the results of the focus groups, cognitive interviews were conducted to assess comprehension of the CycleTel messages by potential users. Both focus groups and cognitive interviews required participants to view and respond to CycleTel messages on their mobile phones to determine how they interpret the
message and understand how the message could be improved. Finally, results of focus group discussions and cognitive interviews were used to refine the CycleTel application that will be tested with a small group of women to determine functionality, ease, and satisfaction with use.

4. Data
Results from the focus group discussions and cognitive interviews, including information about mobile phone use patterns, interest in CycleTel, appropriate messages and message patterns, and implications for including men will be presented.

5. Findings
Previous research showed that the target population for CycleTel is interested in an information-based family planning method – specifically, the Standard Days Method® (SDM) - and is able and willing to use the SDM to avoid unplanned pregnancy. Study results indicate that CycleTel would fit well within typical mobile phone use and SMS habits in the study areas, and that women have significant interest in applying SMS to use the SDM and receive related reproductive health information.

6. Knowledge contribution
CycleTel is the first application that offers an actual contraceptive on a phone. Given the growing popularity of mobile phones worldwide, the availability of such an application on a wide scale would make a significant impact in reducing unmet need. Fertility awareness information—which is the basis of CycleTel—provides individuals with the understanding of their bodies and how to protect them while awakening their interest in other aspects of their reproductive health care. In addition, CycleTel could serve as a core application to which other health-related information could be added. Examples of information that could be offered as part of a CycleTel packages include STI/HIV prevention, counseling, and testing information; condom use information; information on other family planning methods; and linkages to health facilities.

F02: 3
Toll-free hotline spreads information on family planning services throughout the DRC

Jamaica Corker
Population Services International, United States of America; jcorker@psicongo.org

1. Background/Significance
Severe civil unrest throughout the 1990s greatly disrupted reproductive health and family planning (FP) activities throughout the Democratic Republic of Congo (DRC), resulting in limited access for over ten years to FP services information regarding FP. This resulted in an unprecedented decline in the Contraceptive Prevalence Rate (CPR) of modern methods in DRC, from 15% in 1995 to 4.4% in 2002. Efforts to re-establish FP services and products are underway but are limited by the vast size of the DRC, infrastructure challenges and government spending priorities for safety and security. Disseminating information on FP and available services is likewise limited by these factors.

PSI/DRC saw the rise in mobile phone use as an opportunity to help increase access to information on FP following the end of the civil war. In an effort to diffuse FP information beyond the fourteen cities where PSI/DRC is currently funded to implement FP activities, PSI/DRC established the toll-free FP hotline, Ligne Verte (L.V.), in 2005. Since then, the hotline has averaged more than 20,000 calls per year, over 80% of which are from men.

This presentation highlights the use of cell phones as a powerful new tool in the health education toolkit, especially in countries which like the DRC are almost devoid of communications infrastructure. It examines the success of a low-cost intervention (around $8,000 a year) which capitalizes on growing cell phone technology in a challenging, post-conflict situation where more traditional means of IEC for FP are limited.

2. Program: State intervention/activity tested
PSI/DRC launched the L.V. in 2005, the first-of-its-kind pre-paid toll-free hotline in DRC. By calling the L.V. number, callers can speak to a trained educator and get accurate information about family planning and/or a referral to the nearest PSI partner clinic or pharmacy, if one is available in the caller’s location. Information is collected on each caller’s location, age, marital status and question asked. Calls are free only from Vodacom network phones and are limited to two minutes each.

3. Methodology
Data collected from L.V. callers is recorded and analyzed by call volume among provinces, types of questions, caller demographics and, where available, information on caller proximity to program activities. Data shows that 80% of callers are men, most callers ask for basic information on/definitions of FP or birth spacing, call volume appears to be determined more by Vodacom coverage than population size, and women call proportionally more in the evenings. Comparisons will also be made with other toll-free hotlines in challenging settings, namely the HIV hotline operated by the CDC in DRC and FP hotlines from PSI programs in Pakistan and Benin (based on an up-coming research paper by PSI), where men make up 78% and 77% of calls, respectively.

4. Data (if relevant)
Although not designed as data collection or M&E tool, data from the L.V. has the potential to be both insightful to both program activities and FP questions and trends in DRC in general; in some cases L.V. data is the only information available on FP from certain provinces/locations.

5. Findings
• The rapid growth in the cell-phone market allows for calls from remote areas otherwise inaccessible (for security reasons or lack of infrastructure) by more traditional IEC methods.
• Men, a traditionally hard-to-reach segment of the population, make up the overwhelming majority of callers, demonstrating that the hotline is a promising opportunity to reach men with FP information.
• Nearly 8% of total calls in 2008 were from provinces where PSI/DRC has NO FP activities and no promotion of the hotline, indicating that there is an unmet need for FP information outside the current project reach and information on the hotline is spread independently of direct program promotion.
• The fact that the majority of calls are questions regarding information on birth spacing/FP indicates that there is a lack of basic and accurate information on FP throughout the country, particularly among men.
• The hotline’s data has potential to provide base information on FP in DRC and PSI/DRC is evaluating how to better collect relevant data from callers that can inform FP programming in the absence of adequate FP research or data in the country.

6. Program: State lessons learned
• Hotlines and other cell phone technology is one effective way of reaching men with FP messages.
• Data from a toll-free hotline has the potential to provide guidance on program activities and information on FP attitudes, particularly in settings lacking adequate research, if data is systematically collected and evaluated (in a manner that does not compromise caller anonymity or quality of response to questions).

• It is crucial to understand the economic and communication environment when operating a hotline. For example, the decreased market share of Vodacom has impacted call levels in the past two years. PSI/DRC must keep abreast of the rapidly-changing cell phone technology, including re-examining the current cell phone market share to determine whether a different carrier will have greater reach throughout the country.

F02: 4

Digital Portraits of Changing Rural Masculinity in South Africa: Engaging Men in Family Planning and HIV Prevention By Producing and Sharing Personal Stories

Amy Lenita Hill1, Dean Peacock2

1Center for Digital Storytelling, United States of America; 2Sonke Gender Justice, South Africa; amylelena@storycenter.org

Background/Significance:

In rural South Africa, the need to involve men in efforts to promote individual and community health are today widely recognized as key to the success of intertwined family planning, HIV and AIDS prevention, and gender equality work. Programs operated by Sonke Gender Justice (http://www.genderjustice.org.za) over the past several years have found that rural men in the country often avoid visiting clinics and using condoms and ignore calls for monogamy and non-violence due to persistent beliefs about masculinity. Geography, economic status, and education level also affect these trends, with rural parts of the country facing distinct resource challenges when it comes to accessing accurate and affirming health information and services. Additionally, media portrayals of men available via mainstream channels tend often to reinforce a vision of men as potentially irresponsible and violent, which can reinforce defensive attitudes and decreases the likelihood that they will respond to calls for change.

Intervention:

Sonke’s work has shown that many men across South Africa want to play an active role in promoting family planning, HIV and AIDS prevention and treatment, and non-violent, gender equitable relationships. Recognizing that direct male involvement and every-day stories of evolving masculinities have the potential to shift individual behaviors and community norms, Sonke collaborated with the Silence Speaks Initiative (http://www.silencespeaks.org) in 2008, to conduct a series of rural digital storytelling workshops. The purpose of the project was to make local voices and images the centrepiece of local campaigns to promote new visions of masculinity and gender equality in South Africa – key goals in the context of family planning and HIV prevention efforts.

Silence Speaks is an international digital storytelling initiative offering a safe, supportive environment for sharing and bearing witness to stories that too often remain unspoken. The initiative facilitates intensive, participatory production workshops, resulting in short digital videos known as “digital stories.” These first-person stories aim to challenge media legacies of voyeurism and naturalized representation by ensuring that workshop participants, not producers, have primary control over what is said/shown and how events and people are portrayed. The Silence Speaks process is modified to accommodate the languages, literacies, and technologies of a given setting. The guiding vision is to listen deeply, facilitate reflection and transformation, and encourage involvement in collective action to support justice. Silence Speaks stories are shared in a variety of educational, community organizing, and policy advocacy arenas to promote global health and human rights.

Methodology:

A total of three Silence Speaks workshops were held, in the provinces of Eastern Cape, KwaZulu-Natal, and Limpopo. Most of the storytellers were recruited from Sonke partner agencies where they receive health services, attend HIV support groups, or participate in peer education programs. Potential storytellers were briefed on the production method to be used and on the fact that their stories would potentially be shown publicly.

Working with a team of trainers, the storytellers shared their own stories and listened to each other’s stories; recorded first-person voiceover narration; generated photos and drawings with which to illustrate their work; and offered varying degree of input into their finished videos. During the workshops, the trainers talked with the storytellers at length about what content and images they felt comfortable including in their final videos and assisted them with linking individual stories to broader social issues. Sonke and Silence Speaks were transparent about the non-commercial nature of the work and integrated opportunities for personal reflection, solidarity building, and leadership development throughout the process.

Some of the digital stories are told in English, others in Xhosa, Venda, or Tsonga (with English subtitles); all are between two and four minutes in length. Storytellers talk about surviving difficult life experiences, condom use, unintended pregnancy, the role of fathers, and the importance of promoting equality for women and children. Following the workshops, participants were encouraged to join Sonke’s previously-established local Community Action Teams and share their stories as starting points for identifying critical issues in family planning, HIV and AIDS prevention, and gender equity, and discussing/outlining strategies for addressing these issues, ranging from individual behaviour change to institutional/policy change.

Findings:

Preliminary evaluation of Sonke’s rural work, including some assessment of the effectiveness of the digital stories campaign in prompting local change, is being undertaken in July-August 2009. Initial data and exploratory findings will be available for reporting at the conference in November.

Lessons Learned:

While workshop evaluations completed by the digital storytelling participants confirmed previous research that has illustrated how the process supports healing and action, in environments where material and health needs are urgent, questions about who benefits from media making, and in what ways, must be carefully scrutinized. Workshop recruitment and teaching processes must be especially vigilant when it comes to informed consent, privacy protection, education about media representation and its implications, and the need to screen out potential participants who are not materially or emotionally stable enough to truly gain from the experience.

F02: 5

RH Interchange: An Online Tool to Support and Analyze Contraceptive Commodity Funding at the Global, Regional, and National Levels, 2004-2008

Dana Aronovich, Mimi Whitehouse, Jane Feinberg, Joy Kamunyori, Marie Tien

John Snow, Inc., United States of America; daronovich@jsi.com

Background
A new report about global funding for contraceptives suggests that global donors’ support for commodity procurement in the developing world will fall short of the projected need. According to the report, the need for contraceptives will continue to rise, creating a funding gap of almost $200 million annually by 2020 if donor funding remains at or near current levels.

Given this gap, stakeholders working in RH must focus on improving coordination to maximize use of limited resources, ensure best prices, and avoid product wastage and stockouts. There is a critical need for advocacy to increase resources and to strengthen coordinated decision making to address this gap proactively to ensure the reliable availability of contraceptives to millions of women in the developing world.

This paper presents an analysis of data from the RHInterchange (RHI), an online database of contraceptive procurement information. The RHI is the only web-based, regularly updated, global source for contraceptive procurement information which can be used for these purposes.

Main question/hypothesis
The primary questions to be addressed through this research include:
1. What data are stored in the RHInterchange and what are the data sources?
2. How can contraceptive procurement data from the RHInterchange be used for:
   a. Advocacy?
   b. Resource mobilization?
   c. Improved coordination to maximize the use of limited resources?
   d. Reduction of stockouts at the central level in developing countries around the world?

Methodology
Data from the RHInterchange were analyzed to understand recent trends in contraceptive procurement from 2004-2008 in over 140 developing countries around the world to support coordination and advocacy efforts. The RHI data has also been routinely used, together with order planning and other logistics data, to inform global donors about potential impending stockouts and to help mobilize the resources required to avert these stockouts. Trends for important funding and procurement questions were analyzed:
   a. How many and which contraceptives are procured?
   b. Where are they being shipped (countries, regions)?
   c. Who is buying them? (donors, national governments, NGOs)
   d. Who are they buying them from (manufacturers)?
   e. How much are they paying for them?

Data/Findings
The study presents recent trends in contraceptive procurement from the largest global sources of funding. For example, from 2004 to 2006, global funding for contraceptives stayed somewhat level at an average of $124 million per year, but jumped up significantly in 2007 and 2008 to around $180 million per year, mostly due to increases in shipments of male condoms, injectables, and oral pills to sub-Saharan Africa and the Asia/Pacific Region. During the period 2007-2008, these three short-term methods represent the largest portion of contraceptive shipments globally in the RHI; and, sub-Saharan Africa and Asia/Pacific received the largest proportion of funding by far.

In particular, sub-Saharan Africa received the largest value of shipments by far out of the shipments recorded in the RHI for a total of $370 million for the five-year period from 2004 to 2008. The majority of those shipments were made up of condoms, ($110 million), injectables ($108 million), and oral ($68 million) with almost 60 percent of that coming from USAID ($217 million). Funding for contraceptive shipments to this region, as recorded in the RHI, more than doubled over this five-year period from $52.6 million in 2004 to $109.5 million in 2008.

At the national level, Bangladesh received the largest value of shipments in the world at almost $90 million over five years from 2004 to 2008. Seventy-two percent of that was shipments of oral and more than half of it came from USAID. Ethiopia far outranks all other Sub-Saharan countries in value of contraceptive shipments according to the RHI. During this five-year period, Ethiopia received a total of $76.5 million worth of contraceptive shipments, more than half of that ($39 million) in injectables, followed by $17 million worth of implants. Almost $30 million worth of those shipments were purchased with funding from USAID, with another $23 million funded through the World Bank and around $11 million worth of contraceptives from both DKT and UNFPA.

Knowledge contribution
RHI data can be used to understand past and current procurement activity by funding source, method mix, global resource allocation, manufacturer and pricing information. By looking at these past trends, donors and national partners can better plan for the future and for addressing the potential funding gap by mobilizing additional resources and by improving coordination between partners to maximize the use of the limited resources available. RHI can also help these partners to better plan and to stay informed about shipment schedules to reduce the likelihood of stockouts at the national level.

This analysis of RHInterchange data helps with these efforts by presenting trends in quantity, value, distribution, funding source, and other critical data points regarding contraceptive procurement. By better understanding where resources are actually going and reviewing past trends, stakeholders can work towards ensuring contraceptive security into the future.

**A03: Reaching Youth: Contraceptive Access and Use**

**Time:** Monday, 16 November 2009: 2:00pm - 3:30pm

**A03: 1**

**Predictors of contraceptive use among young women in urban northern Nigeria**

Mu'awiyah Sufiyah, Stella Babalola, Hadiza Babayaro

JOHNS HOPKINS UNIVERSITY CENTER FOR COMMUNICATION PROGRAMS KU SAURARA PROJECT, Nigeria; sufianmb@yahoo.com

1. **Background/Significance**
Contraceptive use is particularly low in Nigeria, especially in the northern part of the country. The 2003 demographic and health survey (DHS) showed that contraceptive prevalence rate was only 3.3% in the North-West and 3.0% in the North-East. Although the DHS further showed that contraceptive use was considerably higher in urban than in rural areas, it is nonetheless true that most women in urban northern Nigeria are not using modern contraceptive methods for a variety of reasons, including supply and demand factors. Increasing modern contraceptive use requires evidence-based strategies that focus on the factors that favor positive contraceptive behavior.

2. Research: State main question/hypothesis

This paper aims to assess the socio-demographic and psychosocial factors that significantly predict contraceptive use among sexually experienced young women in urban northern Nigeria. We hypothesize that contraceptive use is a significant function of marital status, age, education and socio-economic status. We also hypothesize that perceived social approval for family planning, discussion of family planning with significant others, knowledge about contraceptive methods and perceived self-efficacy to obtain contraceptive methods are positively related to contraceptive methods.

3. Methodology (including location, setting, period, analysis approach)

Using data collected in three northern states (Bauchi, Kano and Katsina) in December 2006, we estimate logistic regression of current contraceptive use on selected socio-demographic and psychosocial variables. Several models were estimated and the most fitting one was retained.

4. Data (if relevant)

The data that will be analyzed in this paper derive from a survey conducted by the Ku Saurara project in December 2006. The Ku Saurara project is funded by the Packard Foundation and implemented by Johns Hopkins Bloomg School of Public Health, Center for Communication Program (CCP). Currently in its fourth phase, the project targets young people aged 15 – 24 years and aims to reduce early sexual experimentation and unplanned pregnancy, increase the practice of family planning, decrease HIV/AIDS/STI infection rates, and reduce widespread practice of unsafe abortion. The data that will be analyzed in this paper were collected to provide baseline data for Ku Saurara Phase III. The survey was implemented in urban areas of three study states. The respondents were selected through a multistage stratified random sampling. The analyses in this paper will focus on 436 female respondents who were either married or sexually experienced.

5. Findings

The data show that 14.0% of sexually experienced young women are currently using a modern contraceptive method. Contraceptive use is less common among married women (9.0%) than among their never-married peers (28.3%). The factors positively associated with contraceptive use are perceived social approval, awareness about contraceptive method, perceived self-efficacy to obtain contraceptive methods and discussion about family planning with significant others.

6. Research: State knowledge contribution

Program: State lessons learned

Communication programs designed to foster contraceptive use should endeavor to build social approval for family planning, facilitate access to contraceptive methods, promote free discussions about family planning and increase awareness about contraceptive methods.

A03: 2

**Changing Dynamics of Contraceptive Use among Young Adults in India**

**Usha Ram**

International Institute for Population Sciences, India; usharam@iips.net

1. Background: Contraception has been the single most important intervention to reduce burden of unwanted pregnancy as well as to promote healthy living among young adults. An early onset of sexual activity (largely within marriage) and desperate demand on young adults to have child soon after marriage, such interventions are likely to fetch unmatched dividend particularly in case of India. The preliminary analysis of latest data available on contraceptive use dynamics for India although indicates towards wider penetration of both reach as well as acceptability of the family planning services compared to past, yet its access and/or promotion among young adult is extremely limited.

2. Hypotheses: With increased awareness, demand and access, contraception use among married young adults should increase

3. Methodology: Use of simple bi-variate and advance statistical tools as per the need would be made

4. Data: Data from the various rounds of National family Health Surveys for young married adults would be used

5. Findings: Fewer than one in six (16%) married young adolescents women aged 15-24 years in India reported using any contraceptive in 1992-93, about half of which were sterilized. By the year 2005-06, over one in four (27%) of them reported using any contraceptive (nearly one third were sterilized). An encouraging finding from the analysis emerging is that while use of modern spacing methods – predominantly condom – has more than doubled during this period (1992-06), the use of sterilization at early stage of life has remained somewhat unchanged. At the same time, there is an increase in the reliance on traditional methods (periodic abstinence and withdrawal); the percentage of married adolescents reported using traditional methods has risen from less than 4% in 1992-93 to almost 7% in 2005-06. This increase is nothing but an indication of the demand and need for making modern spacing methods socially accessible to young adolescents.

The analysis by a few selected socio-economic characteristics also indicate that dependence on sterilization (mainly female sterilization) is more among married young adults belonging to poorer sections of the society. For example, over half of the users of family planning among illiterate and those less than five years of schooling had used sterilization method. In contrast, among those married adolescents with high school or higher education, less than one-third had reported using sterilization. At the same time more illiterate and less educated young adults reporting using traditional methods such as withdrawal and safe period compared to those who have completed high school or more. This clearly indicates the increasing demand of contraception among young married adults and lack of program services to meet this demand leaving the young adult to rely on the less efficient contraceptive methods. Condom use on the other hand was relatively more common among those with higher education as compared those either illiterate or with very little education.

The analysis further shows great deal of variations in changing dynamics of the contraception use among married young adolescents across different states in the country. Among the states with high HIV prevalence (such as Andhra Pradesh, Tamil Nadu and Maharashtra), condom use among married young adolescents has not changed much over the past 15 years period. As a matter of fact, the condom users in Andhra Pradesh has declined from 1.6% in 1992-93 to just 0.5% in 2005-06.

6. Knowledge Contribution or Lessons Learned: The data increase in the change in use of contraceptives among married young adults. The preliminary analysis also indicates towards an increase in the demand for contraceptive methods by the married young adults. Thus the present paper thus explores contraceptive
use dynamics among married young adolescents in India over time. The paper also attempts to examine changing patterns of contraceptive use among married young adults by a few selected socio-economic characteristics including spatial variations. Further, the relationship between program strength (including policy shift after ICPS 1994) and contraceptive use among married young adults of different social and economic groups is also examined. The data from three rounds of National Family Health Survey would be used for the analysis.

AO3: 3

Peer Educators and School Support: we need education and teachers to support our work on ASRH arena
Regina Benevides¹, Ana Jacinto¹, Arlindo Folige², Åsne Aarhus Botillen³, Kari Cruz³, Carolyn Boyce¹
¹Pathfinder International, Mozambique; ²Ministry of Education and Culture, Mozambique; ³Independent Consultant; jpacca@pathfind.org

1. Background:
The Geração Biz Program (GB) a national adolescent sexual and reproductive health (SRH) program began in 1999. The program aims to improve adolescent SRH outcomes and reduce incidences of unwanted pregnancies, STI and HIV/AIDS.

In its ninth year it is starting its ‘phase out’ with UNFPA and Pathfinder International withdrawing.

Before the school-based initiative of the program is handed over to the Ministry of Education and Culture (MoEC) a complete assessment of the current program was conducted.

2. Hypothesis Tested:
June 2008, this evaluation ‘the Formative Evaluation of School-Based Interventions (FESBI)’ was designed to answer:

a. How effectively are the program’s strategies in improving adolescent RH knowledge, attitudes and behavior? Which strategies are most effective?
b. What standards should be applied to GB schools?
c. What changes should be made to the Program?

3. Methodology
The research aimed to capture program knowledge, perceptions and feedback from people working directly with the GB program: school principals, teachers and school-based activists. Individual interviews, self-administered questionnaire and an observation checklist constituted one of the studies of the evaluation research.

Director and GB Teacher: Individual semi-structured interviews were conducted.

131 Activist Questionnaire: Self-administered it captured information on GB program activities, activists’ knowledge of and comfort level with SRH topics, relationships with school staff and program beneficiaries and general feedback on GB program.

Observation Checklist: General information about the school, the youth corner and GB program activities. Also information on the RSH resources available, and the type and accuracy level of information given.

4. Findings
a. Leadership
The analysis of data from 20 schools reveals specific characteristics that distinguish high performing v. low performing schools (strong/weak). Comparing strong and weak schools, director full involvement was observed as a proxy for stronger performance - support activist’s activities (81.8% vs 37.5%), supervision activities (72.7% vs 27.3%), attend meetings (36.4% vs 25%) .

The support from GB teachers is the other important variable that affects the program’s effectiveness. In low performing schools, the teachers seem to give more practical support and participate in organising of activities.

b. Activists’ knowledge
The school based program has achieved much; using activities increase young people’s knowledge, skills and abilities to adopt safe behaviours. Findings show that 89% of the activists were able to identify at least 2 forms of HIV transmission and that 65% were able to identify 3 of them. Seen in relation to Demographic and Health Surveys for the country, these results are encouraging. The majority (71.7%) of the respondents identified unprotected sex as a way of contracting HIV. This shows that the core message: condoms prevent HIV transmission, has been transmitted.

Inability to identification other major causes of transmissions indicates that knowledge of the disease is limited/fragmented. The activists lack a thorough biomedical understanding of the nature of HIV transmission; e.g. role of semen, blood, and breast milk. Quality SRH knowledge is vital so activists can give correct information, and confront myths surrounding HIV transmission. Further evaluation is needed to assess activists’ SRH knowledge, focus group interviews with students are being done to access; levels of information, students’ opinions and experiences with the services.

The data below shows how activists in high performing and low performing schools react to the situation of not being prepared to answer questions on SRH topics. Strong schools meant:

Ask for help from other activists: 78.7%
Ask for help from GB teachers: 44.7%
Refer the student to SAAJ or other services: 78.7%
Try to respond myself: 10.6% (vs 15.5% - weaker schools)

The findings show that activists in high performing schools report more frequently to be seeking help from other activists and teachers when they feel unprepared to give information on SRH topics. They also have a much higher frequency of referring students to health services.

Activists’ lack of knowledge will, potentially, have more negative effects in schools where leadership and support is weak. It is therefore important for successful program implementation that GB teachers should be present at all GB schools to provide leadership, oversee and serve as a source of SRH information. Director involvement is equally important. Measures should be developed to ensure that activists are competent to ensure program quality.

5. Knowledge Contribution
The study indicates that high performing schools (HPS) are characterised by directors who are knowledgeable about and engaged in the GB program, and teachers who are effective leaders and provide ongoing supervision.

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This model of HPS should be used to create standards and improve the program. Teacher selection is crucial to offer sufficient leadership, supervision, and feedback to the activists. Human resources should focus on how these qualities can be improved.

A03: 4

Improving Contraceptive Access and Use Among the Youth in Lungwena and Makanjira Areas in Rural Malawi

Andrew Ngwira, Effie Chipeta, Linda Kalliani-Phiri, Frank Taulo

University of Malawi, College of Medicine - Centre for Reproductive Health; effie_chipeta@yahoo.com

BACKGROUND: The International Conference on Population and Development (ICPD) held in Cairo in 1994, of which Malawi is a signatory, acknowledged that young people are excluded in most of the national health services and yet they experience ever increasing health problems (1). It is reported that young people in Malawi do not have adequate nor equitable access to family planning services. As a result they are faced with numerous problems like early and unwanted pregnancies, risk of abortion and sexually transmitted infections (STI) including HIV and AIDS (2). This paper outlines some of the results and lessons learned in the youth friendly health service initiative.

INTERVENTION

The youth reproductive health initiative was implemented as a component of a larger project which focused on promoting reproductive health and rights of people of reproductive age in Malawi. The aim of the initiative was to enhance knowledge, access and utilization of modern family planning methods among the youth in the rural communities. The initiative involved training of youths in school and out of school on community distribution of modern family planning methods (YCBD). A total of 15 youths two from each school and from the community were trained. The youth CBD agents provided counseling, motivational talks and distributed modern family planning methods to fellow youths. In addition youth clubs were established in schools to raise awareness among youths on the dangers of early and unwanted pregnancies, abortions and STI and HIV and AIDS. The clubs were run by the youth themselves with the supervision of teachers who were their patrons (primary supervisors) and health centre staff as secondary supervisors.

At the facility level, youth services were integrated into the existing primary care services. This has enabled young people to access the services on a daily basis and at one service delivery point. Service providers and support staff were trained on making health services accessible, acceptable and friendly to young people. Training focused on updating knowledge, skills and positive attitudes in the provision of services to young people.

At community level, community mobilization around sexual and reproductive health and rights was done, Chiefs as gatekeepers helped to demystify some of the cultural beliefs which were barriers to youth seeking services. Community meetings were organized to facilitate dissemination of information and sharing of knowledge between youths and community members.

METHODOLOGY:

This was a development project implemented in the rural areas of Lungwena and Makanjira in Mangochi District along the Eastern Shore of Lake Malawi. The area has a total population of 157, 114, Yao is the predominant ethnic group and majority of the people are Muslims. The project was implemented in the year 2000 – 2006.

A combination of quantitative and qualitative methods were used to collect data. Health Management Information System (HMIS) collected disaggregated data in terms of age and sex and utilization of family planning methods through use of facility registers and YCBD records. Supervision reports, observations and focus group discussions were also used to gather qualitative information. To assess impact of the intervention, qualitative data was analysed through SPPS while qualitative data was processed manually in Microsoft Word.

FINDINGS:

Integration of services and the door to door approach increased the number of youths accessing family planning services at both community and facility level from 12% in 2000 to 28% in 2006. The STI prevalence rate among youth in the area declined from 4.7% (n= 3539.84) in 2000 to 1.9 % (n= 1,431) in 2006. Similarly the number of school dropouts due to early pregnancies also declined from 42 cases in 2000 to 12 cases in 2006. The youth CBD approach increased the contraceptive method mix at community level and modern family planning methods were readily available at non conventional places like football matches, community gatherings and during night activities. Increased interaction and debate on modern family planning methods was noticed through youth clubs and in social places.

LESSONS LEARNED:

A combination of community based and facility based programmes were used to target youth seeking family planning services. Through this approach, various partners were involved in the provision of family planning information and services such as youths, teachers, community leaders, community health workers (HSAs) and service providers at the health facilities. This ensured a wider coverage and improved access to a variety of modern family planning methods to youths in the area. Use of community structures and systems enhanced acceptability of new initiatives.

References


A03: 5

Assessment of the Straight Talk Foundation (STF) Peer Education Approach to sex education in Arua and Bugiri Districts in Uganda.

Julie Wiltshire, Catharine Watson, Jeralom Omach, Patrick Walugembe

Straight Talk Foundation, Uganda; JWiltshire@straighttalkuganda.org

Background / Significance

Straight Talk Foundation (STF) is a Ugandan health communications NGO that began work in 1997. The STF peer education program is aimed at strengthening and encouraging formation of pupil driven Young Talk clubs in primary schools, so as to increase pupils’ access continuous adolescent sexual and reproductive health (ASRH) information and services, life skills education and entertainment activities for positive behavior change. This was to be achieved through implementing peer educator led activities that included music, dance and drama, debates and discussions, group reading and group discussion of Young Talk newspapers.

STF envisioned that this approach would help reduce teachers’ workload for day to day planning, designing and implementing, ASRH programs in the schools, empower the girl child in schools to manage positively the different issues and problems they encounter in their sexuality experiences, including unintended
pregnancies, and to enhance child to child learning which makes children more open about sexuality, reinforcing STF messages and ensure sustainability through the Young Talk clubs. Developing open and positive attitudes towards sexuality at an early age will help students better prepare for teenage years.

**Program - Main Intervention/ Activity Tested**

STF implemented the peer education program in two districts, Arua and Bugiri, targeting a total of 50 primary schools. A total of six pupils from each school (a girl and boy from each of the P5, P6 and P7 class) were selected for training. In the end, a total of 50 primary schools health/Young Talk clubs were strengthened and formed in the two districts. A total 300 Young Talk club members were trained on peer education, club leadership and SRH issues. To contribute to improved SRH environment and to ensure administrative support to the program, a total of 150 administrators including the head teacher, senior woman teacher and a teacher in charge of PIASCY were trained. In addition, the program involved parents as a way of enhancing parental involvement both at school and at home holding parental dialogues in the two districts.

The main purpose of the study was to assess the extent to which the schools have implemented the activities and ascertain the outcomes of the activities at individual and school level. In addition, it was aimed at ascertaining challenges and identifying possible solutions as a way of ensuring continuous effectiveness of the program.

**Methodology**

The study employed a qualitative approach aimed at soliciting for the outcomes of the program through the eyes of the beneficiaries. The study was carried out in the districts of Arua and Bugiri and it targeted, in each school, the peer educators who took part in the program, the head teacher, PIASCY teacher as well as the senior woman teacher. It also involved the pupil community, randomly selected pupils from P5, P6 and P7 to discuss the peer education program through their own understanding. Data was collected through Focus Group Discussions that centered on the activities being implemented in schools, the benefits to individuals and the schools, the challenges they have faced and possible solutions.

**Data**

Findings show that all the schools visited were implementing the activities that were intended by the training workshop, ensuring that the peer education program achieved its expected objectives. In all the schools visited, activities ranged from discussing sexuality messages at school assemblies and gatherings, to creating opportunities for discussions and reading Young Talk, followed by group discussions during music, dance and drama, games and sports activities.

**Findings**

Teachers and school administrators were asked to comment on how the activities carried out had benefited their schools. Positive feedback showed the potential of the program in effecting behavior change. The achievements of the peer education program were categorized into two main sub themes; benefits for individuals and benefits to schools. In general, the benefits to individuals and schools can be summarized under the following sub themes;

- Improved ASRH knowledge and capacity of peer educators and teachers
- Increased dialogue about ASRH issues in schools
- Creation of avenues and opportunities to discuss girls/gender issues

**Program Lessons Learned:**

The peer education program encourages dialogue about ASRH issues in schools. The activities have created a demand for ASRH information, thereby encouraging ongoing dialogue which is a protective factor and fits what is theorized in STF’s “ecological model”. The benefits of the peer education program have been enhanced by a number of factors, some of which were existent in schools while others were contributed by STF. These should be considered in future interventions in relation to peer education, including careful selection of the peer educators and teachers to ensure the aims of the training are achieved, and improved availability of resource materials for peer educators in local languages.

**B03: Contraceptive Use: Levels and Trends II**

**Time:** Monday, 16 November 2009: 2:00pm - 3:30pm

**B03: 1**

**Strong Predictors of the Unmet Need for Limiting and Spacing Births in Sub-Saharan Africa**

Keriann Schullers, Issakha Diallo, Jennifer Litzow, Diana Slimperi

Management Sciences for Health, United States of America; idiallo@msh.org

1. Background/Significance:

Since the 1960’s, family planning programs have achieved great success in raising the global contraceptive prevalence rate from 10 percent to 60 percent and improving women’s lives as well as their socioeconomic conditions. Despite this success, many developing countries are still facing a large unmet need and its devastating consequences. Countries in sub-Saharan Africa (SSA) experience the highest levels of unmet need for family planning worldwide, where approximately 24 percent of married woman have an unmet need for family planning.

2. Research Question:

The primary purpose of this study is to identify the strongest predictors of unmet need for family planning, including for spacing and for limiting births, in order to help policy makers and program managers strengthen current and future family planning programs and reduce the large unmet need in SSA.

3. Methodology:

This study uses multivariate regression analysis to study quantitative data from countries’ most recent Demographic and Health Surveys (DHS). Analysis was conducted on 29 SSA countries with a DHS survey between 2000 and 2007: Benin, Burkina Faso, Cameroon, Chad, Congo, D.R. Congo, Eritrea, Ethiopia, Gabon, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe. Overall, 21 independent variables were examined, including economic, health, social, and demographic factors. The variables were entered into separate step-wise multivariable regression models for the unmet need for spacing, the unmet need for limiting, and the total unmet need.

4. Data:

The results of the multivariate regression analysis for the unmet need for spacing show that two variables appear in the regression models: percent of married women who have ever used any form of contraception (modern or traditional) and percent of women who have had a live birth in the three years preceding the survey and did not receive antenatal care. Approximately 28% of the variance of the unmet need for spacing is accounted for, or predicted by the percent of
married women who have ever used any form of contraception. When the percent of married women who have had a live birth in the three years preceding the survey and did not receive antenatal care enters the model, the results become even more statistically significant (p = 0.002); 41.5 percent of the variance in the unmet need for spacing can be accounted for, or predicted by these two variables.

For the unmet need for limiting, four variables appear in the regression analysis: wanted fertility rate, actual fertility rate, neonatal mortality rate, and the percent of women who have heard family planning messages on the radio in the past few months prior to the interview. Wanted fertility rate appears to be the strongest predictor of the unmet need for limiting (R-squared = 0.422), indicating that 42.4 percent of the unmet need for limiting can be accounted for, or predicted by the wanted fertility rate. When all four of the variables are entered into the model, R-squared remains significant (p = 0.000) at 0.812, indicating 81.2 percent of the unmet need for limiting can be accounted for, or predicted by the wanted fertility rate, fertility rate, neonatal mortality rate, and the percent of women who have heard family planning messages on the radio in the past few months prior to the interview.

Only two variables ended up in the regression models for the total unmet need: population density and GDP PPP. Both models are statistically significant (p ≤ 0.05), meaning we are 95 percent confident that population density and GDP PPP are predictors of the total unmet need. According to our results, approximately 17.5 percent of the total unmet need can be accounted for, or predicted by the population density. When adding GDP PPP into the model, we found that 32.5 percent of the total unmet need can be accounted for, or predicted by both the population density and the GDP PPP.

5. Findings:
The main results from the analysis show that the predictors of unmet need vary significantly by the type of unmet need (i.e., for spacing, limiting, or total unmet need).

6. Knowledge Contribution:
This study helped to identify the major predictors of the unmet need for family planning. More important, it reveals that the predictors of unmet need are specific to each type of unmet need (i.e., for spacing, limiting, and total unmet need); none of the variables were found to be a predictor of more than one type of unmet need. This difference suggests that any further research to be conducted on unmet need should consider the type of unmet need (i.e., for spacing and limiting) rather than examining only the total levels of unmet need.

B03: 2
How Can You Address the Sexual & Reproductive Health Needs of Clients - Including Unmet Family Planning Needs - if You Cannot Say the Word “Sex”

Caroline Mackenzie1, Marsden Solomon2, Alice Olavo1, Ruth Mulia2, Diane Kamar2, Dorcas Kameta3, John Ondodi3, Margaret Meme1, Peter Mwarogo1

1Family Health International, Kenya; 2Division of Reproductive Health, Ministry of Public Health and Sanitation, Kenya; 3National AIDS and STDs Control Program, Ministry of Medical Services, Kenya; 4Formerly Provincial Medical Officer’s Office, Rift Valley, Kenya; cmackenzie@fhi.org

Background:
In the recent years, the high incidence of unintended pregnancies and HIV/AIDS has required that communities discuss sexuality more openly. It is expected that family planning (FP) and HIV service providers would facilitate these discussions in counseling their clients, and providing sexual and reproductive health information and services effectively without fear or embarrassment. However in many communities, discussion about sex and sexuality is taboo even among sexual partners. Service providers are no exception. They carry their attitudes and values into service provision thus hindering effective service provision to sexually active clients. .

To address this barrier, the Kenyan Ministry of Health (MOH) and its partners identified the need to improve the skills of providers in communicating messages on sexuality. To inform this process, an assessment was carried out to document the abilities of FP and HIV service providers to understand, discuss and provide counseling on sex and sexuality to their clients. This presentation reports on the results of this assessment.

Research questions: What is the knowledge, attitude and practice of sexuality counseling among FP and HIV service providers? What are the barriers to communicating messages on sexuality to clients?

Methods:
In June 2008, 10 focus group discussions (FGDs) and 17 in-depth interviews (IDIs) were conducted among selected HIV and RH service providers from three purposively selected provinces. In addition, 18 key informant interviews were conducted with policy makers, program managers, and trainers from selected institutions, with a specific interest in sexuality education and counseling. 131 face-to-face client exit interviews were also conducted with clients from FP, STI, VCT and HIV care and support services, to gain insight into their interaction with the health providers. Structured and semi-structured interview were used. Trained research assistants collected the data for two weeks. Responses from the FGDs were tape recorded, transcribed and analyzed using ATLAS Ti. Those from the IDIs and key informant interviews were entered and analyzed using EPI INFO.

Results:
There was a general lack of knowledge and training on sexuality counseling among FP and HIV service providers, partly because there is insufficient focus on sexuality within the current training curricula. Service providers may gain some knowledge through experience or personal interest, but there is no standardized training in human sexuality. As a result, providers lack the knowledge and predisposition required to engage clients in discussions on sex and sexuality. Most reported that they felt uncomfortable if a client asked about sexual practices considered to be negative/taboo, such as anal and oral sex, masturbation and transactional sex. Ten out of 17 service providers said that if a client asked them about same sex relationships, they would discourage it. Also, 12 out of 17 service providers did not know that anal sex is the most efficient mode of acquiring HIV. Asked about ‘lower risk’ sexual practices that discordant couple could use, four out of 17 providers did not know what advice to give.

Service providers identified client-provider differentials (for instance some FP service providers expressed discomfort offering FP services to the youth), insufficient skills, limited knowledge and discomfort with the subject matter, as the main barriers in communicating messages on sexuality with clients. Other service providers were concerned about the image they would portray to clients if they initiated discussion on sexuality and feared that they could be misunderstood, and thus chose to wait for the client to raise questions. Also, both program managers and service providers mentioned that time was a significant constraint in engaging in sexuality-related discussions with clients. Often providers had too many clients to attend to, sometimes operating in more than one working station in a day. In addition, lack of audio and visual privacy hindered any meaningful discussion on sexuality with clients beyond dealing with the immediate problem the client presents.
Conclusions:
There is a knowledge, attitude, and skills gap that hinders effective communication on sex and sexuality with clients. Unless this is addressed, there will be missed opportunities to prevent unintended pregnancies and the acquisition of HIV and STIs. In response to the assessment findings, MOH is developing and evaluating training materials for providers on sexuality.

B03: 3
Wanted and Unwanted Fertility, Need for Family Planning and Contraceptive Use Dynamics in India
Hemkothang lhungdim 1, Nikhiltesh S. Parchure 2
1International Institute for Population Sciences, India; 2Population Research Centre, Sagar, India; lhungdim_hem@yahoo.com

BACKGROUND:
India is the second most populous country in the world. Slow pace of fertility decline is, therefore, a major concern for population stabilization efforts in the country. According to NFHS-3 survey conducted in India in the year 2005-06, the total fertility rate is 2.7 children which is well above the replacement level. India also has a distinction of first initiating government sponsored family planning program. Couple protection rate has increased from less than 10 percent in 1960s to about 60 percent recently. Despite the achievement, unmet need, coupled with clustered services, for family planning continues to be high in India. In six most populous states of India, 42 percent of all the births were unwanted/unplanned or mistimed. This provides the opportunity to relook into the determinants of unmet need and areas of high unwanted pregnancies in India.

HYPOTHESIS:
Contraceptive use is determined by family size.
Unwanted/mistimed births hugely affect fertility level
Unmet need for family planning is determined by service availability of family planning.
Met and Unmet need for family planning is determined by economic wellbeing of the family.
Determinants of unmet need are different for men and women.

METHODOLOGY:
Unmet need for family planning is defined as percent of women who are not using any contraception but want no more children or want them later. Univariate and bivariate methods have been used to determine the differentials in unmet need. Logistic regression analysis has been used to see the determinants of unmet need at state level and for males and females separately. To see the economic impact on unmet need different logistic regressions have been obtained for different wealth quintiles.

DATA:
Present study uses data from National Family Health Survey (NFHS-3) in India in 2005-06. NFHS-3 collected information from a nationally representative sample of 124,385 women age 15-49 and 74,369 men age 15-54.

FINDINGS:
Twenty-one percent of births that took place in India during 5 years preceding the survey are unplanned, i.e. unwanted or mistimed at the time the woman become pregnant. There is a variation in difference between wanted and total fertility among Indian states; it is lowest [0.1 children] for Kerala and Highest [1.6 children] for Bihar. Six states Uttar Pradesh, Jharkhand, Rajasthan, Madhya Pradesh, Nagaland and Bihar accounts for about 42 percent of all unwanted births in India and a difference of more than one child in wanted and total fertility. Multivariate analysis shows that, women with no education, Muslim women, women from scheduled tribes and women in households in the lower two quintiles are having higher unwanted births leading to a gap of more than one child in wanted and total fertility. In NFHS-3, 13 percent of currently married women in India have unmet need for family planning. Unmet need for spacing is slightly lower than for limiting. Unmet need in two lowest wealth quintiles is 33 percent while it is only 8 percent in the highest wealth quintile. Logistic regression analysis shows that women with no medical facility nearby is twice as likely to have unmet need as that of women with a medical facility nearby. Exposure to education, mass-media leads to the higher use of contraceptives among poor women and men.

KNOWLEDGE CONTRIBUTION:
Wealth index which is a summary measures for economic status of a household, provided vital linkages for determinants for unmet need among poor. The assessment of need for family planning among poor and rich is crucial to the success of countries population and family planning programs. It enables policy makers and program managers to estimate the market for family planning services and assess program effectiveness. Family planning programs must address unwanted/mistimed births as they are crucial to understanding of high fertility and maternal health.

B03: 4
Retrospective case notes review of Minilaparotomy and No-Scalpel Vasectomy procedures performed at Dessie FGAE clinic, North East Ethiopia: a 10-year period review
Netsanet Fetene
Engender Health, Ethiopia; netsanetfetene@yahoo.com
1. Background/Significance
Male and female sterilization is a safe and effective form of permanent contraception. Despite the large segment of women and men in need of limiting there family size, the surgical contraception method choice remain poor in Ethiopia.
2. Research: State main question/hypothesis
Program: State intervention/activity tested
The objective was to review and evaluate the socio-demographic characteristics and clinical course of clients who underwent voluntary surgical contraception (VSC) through Minilaparotomy (mini-lap) and No-Scalpel Vasectomy (NSV) in the last ten year period
3. Methodology (including location, setting, period, analysis approach)
A case series design where by pre- and post-operative conditions of clients coming for voluntary surgical contraception via minilaparotomy and No-Scalpel Vasectomy were systematically analyzed. The setting for the study was the Family Guidance Association of Ethiopia (FGAE) Dessie model clinic and seven outreach mobile VSC sites. All of 984 clients who decided to use tubal Ligation (TL) and vasectomy method of contraception from March 1997 to Nov 2007 G.C were included in the study. A format prepared and distributed to Voluntary Surgical Contraception (VSC) providing sites in Ethiopia by FGAE was used in collecting the necessary information, including informed written consent from clients.

4. Data (if relevant)
5. Findings

Nine hundred sixteen (93.1%) women underwent tubal sterilization through mini-lap. Sixty eight (6.9%) men underwent vasectomy under No-Scalpel Vasectomy. The mean age of clients for having VSC is 35.7 years±5.6 years (34.9±4.3 years for TL and 46.9± 9.7 years for vasectomy).The mean number of live children per client was 5.8±1.6 children, with parity ranging from two to thirteen children. Clients with six or more children were 555 (56.8%).The average length of the time since making a decision not to have any more children was 2.3 years +/- 2.1 year (median of two year). The rationales given for permanent family planning were economic, ill health and completed family size. Regarding the pattern of decision making, in 693 (75.1%) of clients both the couples were involved in decision making. The majority of surgery was performed by general practitioners 756(79.8).All except two underwent the procedure under LA and no major complication was encountered during surgery. The mean operation time was 25.7 min±10.7 min for TL and 26 min±15.2 min for vasectomy. Follow-up attendance during one-year period reported no serious problem.

6. Research: State knowledge contribution
Program: State lessons learned
Tubal sterilization through mini-lap and No-scalpel Vasectomy under LA is an ideal method in developing countries to reach the underserved population where access to family planning and other reproductive health services are not widely available. Trained General Practitioners on VSC can provide safe and effective female and male surgical sterilization at rural health set-ups through mobile outreach services.

C03: Gender as a Social Determinant in FP

Time: Monday, 16 November 2009: 2:00pm - 3:30pm

C03: 1

Do contraceptives fail? Investigating Claims of Contraceptive Failure among Women of Reproductive Age in Nigeria

Oladipupo Banji Ipaedeola, Samson B Adebayo, Jennifer O Anyanti

Society for Family Health, Nigeria; ladiipadeola@yahoo.com

Background

The provision of contraceptives for family planning and birth control has received more attention from the international communities and donor agencies in recent times. While family planning clinics and health facilities are equipped with family planning products, more family planning methods are being introduced to meet the physiological and hormonal requirements of intending users. However, the low contraceptive uptake has been anchored on failure of the method which in turn discourages the potential users.

Activities tested

Although several works have been published on family planning, there is little or no information on incidence or claims of contraceptive failure among users of modern family planning methods in Nigeria. This paper attempts to investigate the claims of contraceptive failure among women of reproductive age in Nigeria and also to explore possible factors that may be responsible for such failure if at all it exists.

Data

The Federal Ministry of Health [Nigeria] in collaboration with the Society for Family Health received funding from the United States Agency for International Development (USAID) to conduct a population-based household survey on HIV/AIDS and Reproductive Health (NARHS) in Nigeria in 2007. NARHS was aimed at providing information on the situation of reproductive and sexual health and the variety of factors that influence reproductive and sexual health in addition to other issues. Eligible respondents for the survey were women (15 to 49 years) and men (15 to 64 years). Selection was based on a multi-stage probability sampling technique. In total about 5338 women of reproductive age were included in the survey. Analysis was based on the response to the question on whether a respondent experienced pregnancy while using a modern family planning method.

Methodology

Multiple logistic regression technique was used in exploring possible determinants and factors that may be associated with the outcome variable. Included in this analysis were occupation, marital status, age at the time of pregnancy, level of education, place of residence, geopolitical zones and type of contraceptives used. All analyses were performed using SPSS version 16 and STATA SE 9.2. We define the response variable as y = 1 if the respondent became pregnant while using contraceptives and y = 0 if otherwise. All tests were carried out at 0.05 level of significance.

Findings

Out of the 5,338 women involved in the survey, only about 22.1% (1,172) have ever used contraceptives; of which 35% (410) have experienced contraceptive failure. Women below 25 years were found to have reported the highest cases of contraceptive failure (85%) while self employed women were more affected compared with women in any other job category (about 41%). Findings also showed that higher proportion of women from rural areas experienced contraceptive failure compared with their urban counterparts (54.1% vs. 45.9%); while more than three quarter of the reported cases were from the currently married women and women living with a sexual partner (87.3%). Considering type of contraceptive methods used as at the time of pregnancy, daily oral pills accounted for about 21.5% of contraceptive failures, while condoms and injectables accounted for 19.6% and 13.9% respectively. Turning attention to the findings from logistic model, women living in urban areas were about 1.4 times more likely to experience contraceptive failures than women in rural areas [P value <0.05]. Women with secondary and higher levels of education were about 2 times more likely to experience contraceptive failure than women of lower educational level [P value < 0.001]. Significant geographical variation was observed at the level of geopolitical zones with p<0.05 except in the South East and South South.
Lesson Learned
It was evident that a significant proportion of the women who were on contraceptives experienced pregnancy during the period they were using it. Pills accounted for the highest proportion of reported failure cases. This could be as a result of users not adhering strictly to the doctor’s prescription or inconsistent use. Findings from this paper revealed that there is need to further elicit information on reasons or adherence to instructions and prescription especially with oral pills contributing to the highest failure rate. Findings from this paper will provide opportunity to enhance appropriate policy formulation and reprogramming.

CD3: 2

Trends in women’s autonomy, sexual activity and contraceptive use in sub-Saharan Africa: A multi-country analysis
Carie J. Muntifering, Michelle J. Hindin
Johns Hopkins Bloomberg School of Public Health, United States of America; cmuntlife@jhsph.edu
Trends in women’s autonomy, sexual activity and contraceptive use in sub-Saharan Africa: A multi-country analysis
Michelle J. Hindin and Carie J. Muntifering

Background/Significance:
Since the International Conference on Population and Development in Cairo in 1994, there has been increasing interest in promoting women’s empowerment and gender equality, particularly for sexual and reproductive health. Despite this interest, only a limited number of studies have examined the relationship between women’s autonomy and reproductive behaviors. There is some evidence from prior research that household decision-making is related to women’s reproductive behavior including contraceptive use. Exposure to sexual intercourse, on the other hand, has consistently been overlooked in research especially in regards to women’s ability to negotiate the timing of intercourse with an intimate partner. In this study, we explore the relationships between women’s autonomy, recent sexual intercourse and modern contraceptive use in five sub-Saharan African countries: Malawi, Mali, Rwanda, Uganda and Zimbabwe.

Hypotheses:
We hypothesize that greater joint decision-making will be associated with higher modern contraceptive use compared to husband only and wife only decision-making. Due to a lack of prior research on the association between women’s autonomy and recent sexual activity, we did not put forth a hypothesis for this association.

Methodology:

The most recent round of DHS for each country was used to conduct multivariate analyses on the associations between women’s autonomy, recent sexual intercourse and modern contraceptive use. Our sample for the multivariate analyses is comprised of married women ages 15-49 who were neither in polygynous unions nor pregnant at the time of the survey. Logistic regression and multinomial logistic regression with survey weights were used to analyze the relationship between household decision-making and recent sexual activity and contraceptive use. Variables measuring socio-demographic characteristics and reproductive attitudes and behaviors were included in all multivariate models.

Data:
Women’s autonomy was measured through household decision-making in which we created three summative scales measuring number of decisions in which the woman only, husband only, and both husband and wife had the final say. Recent sexual intercourse was separated into a dichotomous variable of whether or not the respondent reported intercourse in the four weeks preceding the survey. Contraceptive use was coded as a categorical variable (no use, traditional methods and modern methods).

Findings:
In examining the trend data we find that decision-making is remarkably stable in most countries, except in Zimbabwe where a considerable increase in joint decision-making is observed over time. Overall, male decision-making is normative, although there is a slight shift over time in favor of joint decision-making in most countries. An increase in women’s decision-making was observed in Rwanda only. The proportion of women who report sexual intercourse in the last month declined in three of five countries, with the remaining two showing some increase. Recently, contraceptive use increased in Mali, Rwanda and Zimbabwe, but only slightly in Malawi and declined in Uganda. During the most recent DHS survey, the contraceptive prevalence rates across these five countries ranges from 15.4% in Uganda to 58% in Zimbabwe.

Based on the multivariate models, we find a strong relationship between greater women’s autonomy and lower rates of intercourse in the last month in all five countries. This association was consistent even after controlling for factors such as the husband living elsewhere and fertility preferences. In Rwanda, Zimbabwe, and Malawi, more joint decision-making was associated with higher modern contraceptive use, while in Uganda, greater women’s autonomy was associated with higher modern contraceptive use. Greater women’s autonomy was associated with a decreased likelihood of using a modern method in Rwanda. In Mali, there was not a significant relationship.

Knowledge Contribution:
Despite increased attention given to women’s empowerment over the past 15 years, male decision-making in the household remains prominent in four out of the five countries. The results from the multivariate analyses, however, suggest a need to continue efforts in improving equality in household decision-making to foster further advancement in sexual and reproductive health. Given our heterogeneous selection of countries it is not surprising that we did not find the same associations between decision-making and contraceptive use in every county; however, it is evident that husband only decision-making is not associated with improved contraceptive use in any setting. A clear, consistent pattern was observed between women’s autonomy and lower rates of recent intercourse in all five countries. This association warrants further investigation but could be evidence that greater women’s autonomy in the household results in women’s improved ability to negotiate sexual frequency with her partner.

CD3: 3

Gender equitable teachers support contraception and small family norms: Findings from a school based intervention in India
Pranita Achyut, Nandita Bhatia, Ravi Verma
International Center for Research on Women, India; rverma@icrw.org
Background and Significance

Although there is increasing awareness of the role that norms encouraging gender inequality play in fostering negative sexual and reproductive health outcomes, few studies have attempted to influence these norms and measured changes among young men and women in different settings. This paper discusses findings from a school based intervention among teachers to influence their gender attitudes and assessing the impact of change in gender attitudes on family planning related attitude and behaviors.

Hypothesis or Intervention/Activity Tested

Intervention involved integrating interactive group education activities related to gender construction, power relation, patriarchy and violence into the teacher’s training curriculum. The activities were based on participatory methods of learning with extensive use of role plays, games and exercises that engaged teachers in discussion, debate and critical thinking. Using these modules 412 teachers were trained.

Methodology

Pre- and post-training tests using measurement around domestic role and responsibilities, decision making, mobility, violence and family planning were carried out. GEMS items were adapted and used for evaluating the program.

Key Findings

The proportion of teachers disagreeing with the statement that “It is a woman’s responsibility to avoid getting pregnant” increased from 67 percent in pre-test to 76 percent in post-test. No variation was observed between male and female teachers or by age. Changes in the notion of responsibility related to FP was also related to a generally more gender equitable attitude in their relationship, as measured through other indicators, such as involvement in household chores, role in decision making, negotiation in sexual relationship and violence. Among teachers who exhibit more gender equitable attitude and were less controlling of women, significantly higher proportion disagreed with the statement that “It is a woman’s responsibility to avoid getting pregnant”. Among those who disagreed with the statement that “There are times when a woman deserves to be beaten”, 59 percent also disagreed with the statement that “It is a woman’s responsibility to avoid getting pregnant” compared to 55 percent who agreed to the statement that woman sometime deserves to be beaten.

Knowledge Contribution or Lessons Learned

The knowledge about the intervention effect and acceptability in the public education system will provide critical lessons for its replication and scale up. Most current in-school programs are limited to giving knowledge and information and rarely delve deeper into critical reflection of underlying attitudes and norms and subsequent reproductive health outcomes.

CO3: 4

Gender Equity, Gendered Roles and Reproductive Health in Maasai Women in Northern Tanzania

Lauren Katherine Birks,1 Yadira Roggeveen,2 Jennifer Margaret Hatfield1

1University of Calgary, Canada; 2Endulen Hospital, Tanzania; lkbirks@ucalgary.ca

Background

Gender inequities leading to biases in power, control, access to resources, social norms, and values are pervasive in all societies (World Health Organization, 2008). Gender acts as a social stratifier that contributes to power hierarchies, which lead to disparities in health outcomes and inequity of health and reproductive rights (Sen, Ostlin & George, 2007). Gender inequity and gendered power relations are expressed in health as inequalities in the form of “differential access to and control over health resources within and outside families, unequal divisions of labour” (WHO, 2008, p. 145).

When examining sexual and reproductive health of women, gender inequity and differential power relations lead to a “reduced voice, decision-making power, authority, and recognition for women relative to men” (WHO, 2008, p. 145). As the influence of gender inequity has increasingly been recognized, change has been called for in the third Millennium Development Goal, as a focus on promotion of gender equality and empowerment of women (United Nations, n.d.). Although not limited to sexual and reproductive health and rights of women, improvements in gender equality and increased empowerment of women have the potential to decrease the burden of work experienced by women in relation to maternity, as well as to weaken “the links between sexuality and childbearing” (Sen, Ostlin & George, 2007, p.15). By weakening the link between sexuality and childbearing, women are more able to be educated, to spend less time bearing and raising children, and to increase their ability to control their own sexuality and reproduction.

In the Maasai community, living in the Ngorongoro Conservation Area (NCA) of Northern Tanzania, gendered roles and responsibilities translate into substantial differentials in power relations, control over individual and familial health, and access to health resources. Relating to sexual and reproductive health, these differentials result in an inability of women to exercise autonomy and to make informed choices over their reproductive lives. The consequence of lack of control over fertility and sexual health is directly linked to pervasive gender inequity, making Maasai women more vulnerable to maternal morbidity and mortality, intimate partner violence and sexually transmitted infections, such as HIV (WHO, 2008).

Intervention

Initiatives to improve gender equality in the form of improved reproductive health of women in the community are focusing on identifying ways to more accurately understand how gender roles and power hierarchies influence sexual and reproductive health, including birthing practices. By developing an improved understanding of gender roles and decision-making power around sexual and reproductive health in the Maasai, the hope is to implement a more holistic approach to maternal healthcare at Endulen Hospital, the only hospital serving the Maasai population living in the NCA.

Methodology

Participatory action research (PAR) methodology and gender analysis are being used to conduct this research. Specifically, both PAR and gender analyses seek to incorporate the non-experts/co-researchers (Maasai women) into the research and to engage vulnerable people who share common problems (gender inequities relating to reproductive health). The researcher collaborates with participants to examine the gendered roles and responsibilities, as well as to seek and enact solutions to problems identified in the community that contribute to gender inequity and negatively effect reproductive health. This process is termed as cogenerative inquiry, where knowledge is cogenerated through collaborative communication between research and co-researchers, which generates action that is linked to social change (Greenwood & Levin, 2003).

Findings

Previous attempts to reduce gender inequities relating to the health of Maasai women have been met with many barriers, including traditional cultural practices, such as polygamy, that are conducive to retention of related gender inequities for women and their sexual and reproductive health (Coast, 2007). Although this initiative is in preliminary phases, findings currently confirm the existence of such barriers to increased gender equity, particularly in relation to
decision-making control over sexual and reproductive health for women. It is clear that Maasai women of all ages experience significant gender inequities relating to work burdens, childbearing and raising and sexual obligation to men. It is also evident that such inequities play a significant role in reducing the agency women have over their own reproductive and sexual health, thereby increasing the likelihood that their well-being is also negatively affected.

Knowledge Contribution
Although these are preliminary results, these initial findings indicate that Maasai women living in Ngorogoro are at high risk of experiencing poor sexual and reproductive health, which includes the ability to control fertility and exercise sexual agency. Such knowledge is significant for the community, as the population is increasingly experiencing pressures that are directly linked to sexual and reproductive health, such as HIV/AIDS. Therefore, this knowledge can be used and expanded up to continue with this same project to provide such women with the opportunity to develop agency over their own sexual and reproductive health and to potentially reduce the associated risks, such as unwanted pregnancies or exposure to HIV.

C03: 5

Qualitative Research on Gender Norms and Family Planning Decision-Making in Tanzania
Sidney Schuler1, Elisabeth Rottach1, Peninah Mukir2
1AED, United States of America; 2Steadman group; sschuler@aed.org

1. Background/Significance
Gender inequality and the norms surrounding masculinity, femininity and male-female relationships can impede the healthy timing and spacing of pregnancies in a variety of ways. Gender norms often support high fertility, influencing the timing of marriage and childbearing and aspirations regarding family size and sex composition. Women’s ability to access health facilities is often limited by limits on their mobility and by economic constraints. Family planning programs and services have often selectively accommodated rather than challenged prevailing gender norms by targeting family planning towards women and reinforcing the idea that reproduction and family welfare are women’s responsibilities. Experience suggests that the incorporation of gender approaches into family planning (FP) and reproductive health (RH) programs may increase their impact, but further work is needed to examine the role of gender norms in relation to family planning and to design appropriate gender norm behavior change communication (BCC) strategies for specific social contexts.

2. Research: State main question/hypothesis
The objectives of this qualitative study are to 1) collect new data regarding the role of gender norms in reproductive decision-making and contraceptive use among young married men and women in Tanzania; 2) analyze the role of gender norms in reproductive decision-making and contraceptive use among young married men and women in Tanzania; 3) develop recommendations for behavior change interventions that address gender-related barriers to effective family planning choices in Tanzania.

3. Methodology (including location, setting, period, analysis approach)
Sites: The study was undertaken among ethnically mixed populations in urban Temeke District, Dar es Salaam Region; and rural areas in Mbeya and Mwanza Regions of Tanzania.

Samples, data collection methods and data: The data consist of open-ended, in-depth interviews (IDI) administered face-to-face by same-sex interviewers with 72 individuals, and six focus group interviews (FGD), one with men and one with women in each site, with about six participants per group. 24 IDs were conducted in each of the three sites—10 each with recently married (married less than five years) men and women, and four with mothers-in-law and other key decision-makers as identified in the interviews with the young men and women. Six of the recently married men and women in each site were recent adopters of contraception and four were former or never-users of contraception.

In keeping with standard research principles, the IDI guides were designed to elicit individual perceptions and experiences, while the FGD guides were designed to identify and elaborate on shared norms. The IDs explored the decision-making processes that influence the timing and spacing of pregnancies, both in relation to delaying the first pregnancy and to the spacing of subsequent pregnancies. Within this broad context, questions elicited the ways in which gender norms influence the timing and spacing of births; the use and non-use of family planning; method choice; and related behaviors that may be amenable to change through BCC interventions. The FGDs explored the cultural meanings of masculinity and femininity. Both the IDs and the FGDs elicited men’s as well as women’s perceptions and expectations of men’s and women’s gender roles in FP and RP decision-making. The IDs elicited men’s and women’s images and expectations of themselves and their spouses, and their experiences in making (or avoiding) family planning decisions and, as applicable, using contraceptives. The IDs explored cultural norms related to gender, reproduction and FP and couples’ discussions about these topics. Interviews were audio-recorded, transcribed and translated into English by independent translators.

Qualitative analysis requires a search for patterns and for concepts that help explain the patterns. Upon completion of the data transcription, the Tanzanian field research team will review their interviews and list key themes. Two AED researchers will then conduct a participatory analysis workshop in which the themes are reviewed, patterns identified and preliminary conclusions drawn. They will develop a codebook describing each theme and the nature and scope of the material to be coded. Rules will be established for coding text that may pertain to more than one theme. The researchers will then thematically code the transcripts using a software program (MAXQDA) that enables the cross-classification and retrieval of transcripts and segments of text by theme. In addition, narrative analysis will be conducted with entire transcripts rather than coded material. The investigators will review the transcripts and coded material findings and interpretations, noting variations in the findings by type of interview and respondent.

4. Data (see above)

5. Findings
Data analysis is underway.

6. Research: State knowledge contribution
This qualitative study is intended to provide data for the design of interventions addressing gender norms and family planning. It is anticipated that AED and T-MARC/Tanzania will implement these interventions on a trial basis as part of a subsequent operations research project.

D03: Integrating FP and Maternal and Child Health I

Time: Monday, 16 November 2009: 2:00pm - 3:30pm

D03: 1

FP Use Among Postpartum Women in 15 Countries
Family planning (FP) use during the first year postpartum has the potential to significantly reduce unintended pregnancy. Research has demonstrated a large unmet need among this group (Ross and Winfrey, 2001). Meeting these needs would substantially increase contraceptive prevalence as well as reduce maternal and child mortality (Cleland et al, 2006). However, little is known about factors that influence FP use during the postpartum period. This paper describes the extent of unmet need, the characteristics of FP uptake during this period, and outlines potential strategies to address these needs.

Methodology

FP use is influenced by many factors including breastfeeding, return to sexual activity, and return of menses. Given the evolving nature of these factors, the postpartum period is defined as twelve months and is divided into 0-3, 4-6, 7-9, and 10-12 months. The accepted definition of unmet need underestimates the extent of unmet need during this period as the usual definition defines unmet need among amenorrheic women based on whether the most recent birth was wanted or was spaced according to the expressed preferences of the woman. Using an alternative definition expands increases the number of women with unmet need two to three fold. For example, in Ethiopia 40% (standard definition) compared to 86% (alternative definition) of postpartum women have an unmet need. In this analysis, the alternative definition is used.

Data

This paper uses the most recent Demographic and Health Surveys in the following 15 countries: Bangladesh, Democratic Republic of Congo, Ethiopia, Guinea, Haiti, India, Kenya, Malawi, Madagascar, Nigeria, Pakistan, Rwanda, Tanzania, Uganda and Zambia. A sub-set of postpartum women is examined for each country, representing an aggregate of 36,576, with an average of 1,780 (excludes India from average) women per country. India has a large dataset with 11,649 postpartum women.

Findings

In almost all 15 countries unmet need declines from the beginning to the end of the postpartum period. In Bangladesh, unmet need declines from 81% to 42%. In general, in countries with low use of long acting and permanent methods (LAPM), both the use and method mix of FP methods approaches the levels and distribution in the general population by the end of this period. In countries with higher use of LAPMs, FP use does not reach such high levels and the method mix is more heavily weighted toward short term methods. In India where sterilization is the dominant method, 46% of non postpartum women compared to 26% of postpartum women use FP.

FP uptake is associated with return of menses. Women whose menses has returned are more likely to use FP than women whose menses has not returned. In Bangladesh, 70% of women whose menses has returned use FP compared to 7% whose menses have not returned. LAM is sporadically reported across the surveys analyzed. An important component of LAM, breastfeeding, is more frequently reported. In most countries exclusive breastfeeding until six months is not practiced by large proportions of women.

Uptake of FP in the postpartum period differs across women of different age and parity. The most vigorous uptake is among women 25-29 years. In two-thirds of the countries women aged 25-29 were more likely to be using FP than women younger than 25 and older than 30. Consistent with findings from previous analyses contact with the formal health system for antenatal care (ANC) and delivery is strongly correlated with FP uptake. In most countries, women with 4+ ANC visits are more likely than women with one visit to initiate FP use. Similarly, women who deliver at an institution instead of home are more likely to use FP.

Knowledge Contribution or Lessons Learned

The alternative definition of unmet need is important since it allows a prospective estimation. It also provides an important rationale for FP integration with maternal, newborn and child health (MNCH) services. The provision of LAPMs as part of FP programs appears to be an important factor in addressing unmet need among this group.

The finding that menses return is associated with FP use is important because it validates anecdotal observations that women wait until menses return before seeking FP services. Programs can develop behavior change strategies to address this issue, as well as to better support early FP uptake among younger and older age groups.

Finally, as MNCH programs work to support multiple contacts with the health systems, it appears that these contacts also support FP use.

D03: 2

A literature review of the integration of family planning services with other health services

Anne Katharine Sebert Kuhlmann1, Christine Galavotti1, Lorrie Gavin2

1MANILA Consulting Group, Inc., United States of America; 2U.S. Centers for Disease Control and Prevention; zmt8@cdc.gov

Background/Significance

Despite decades of progress in the delivery and availability of family planning services, high levels of unmet need for family planning still exist in many countries. This continued unmet need for family planning suggests that novel approaches are needed to reach women and couples who desire to limit or space their child-bearing but who are not currently using contraception with family planning services. The integration of family planning with other health services may provide one such opportunity to reach women and couples with an unmet need for family planning. Before investments are made in promoting integration as an opportunity to help fulfill this unmet need for family planning, however, an evidence base needs to be established supporting the effectiveness of such an approach. Therefore, we conducted a literature review of programs that have attempted to integrate family planning with other health services. While others have reviewed the integration of family planning with specific types of health services (see Colombini et al. 2008, Rutenberg & Baek 2005, Askew & Maggwa 2002, Dehne et al. 2000, Mayhew 1996; Wallace et al. 2009), we reviewed the integration of family planning services with any other health service.

Research question
Our literature review sought to answer the question what is the current state of knowledge about the effectiveness of and best practices for integrating family planning services with other health services?

Methodology

We conducted a broad search of the literature to identify strategies, field experiences, and program evaluations for integrating family planning with other health services. We searched key literature databases (e.g., PubMed, EMBASE) and the Cochrane database for English-language articles published between 1994 and 2008. We identified articles that described a strategy, intervention or program effort to integrate family planning with other health services, either new or existing services. We reviewed 7 articles that described a process, field experience, or program effort for integrating family planning with other health services; 10 articles that discussed strategies for integrating family planning with other health services – including community-based efforts; and 6 articles that debated the appropriateness and feasibility of integrating family planning services with other health services.

Findings

To date, much of the published literature on the integration of family planning services with other health services focuses on integrating family planning with other sexual and reproductive health services, e.g., HIV/AIDS or STD prevention, screening and treatment. Most of the emphasis has been placed on creating more comprehensive maternal and child health services or sexual and reproductive health services. In addition, we found one example of a pilot project integrating family planning with a water and sanitation program (Lundgren et al. 2005) and an example integrating family planning with an immunization program (Huntington & Aplogam 1994). Most evaluation efforts included in this review suggest some positive outcomes of integrated programs, but rigorous evaluations of integration efforts are lacking.

Furthermore, there have been limited efforts to capture the clients’ or communities’ perspectives on integration. There is some evidence, however, that community-based outreach efforts have been successful – such as using community health workers or community-based distributors to create demand for or make referrals to integrated clinical services, provide contraceptives, reach men and women in their own homes, and mobilize community members. Despite these successes, most integration efforts have been focused around clinical services. Less emphasis has been placed on the integration of preventive and community-based activities – areas which might lend themselves to integration more easily than clinical services.

Several articles provide considerations for the implementation of integration efforts. These considerations include securing political and donor commitments to the effort; streamlining policies, guidelines, trainings, and manuals; involving community participation; considering how patient flow will need to be modified; and securing commodities and materials for integrated services. It is unclear, however, what exact factors are associated with successful integration because, to date, the evaluation of such programs and services has been weak.

Knowledge contribution

The results of our literature review indicate that currently there is very little evidence to support (or not support) the integration of family planning services with other health services. An evidence base still needs to be established around how best to integrate family planning with other health services. Questions remain as to the cost-effectiveness of such an approach, the most effective service delivery model for integrated services, and the compatibility of different services to be integrated. The existing literature does, however, help generate hypotheses about the integration of family planning services with other health services. For example, many family planning programs are strong in prevention and non-clinic-based support services – which should provide opportunities for integration efforts. Nevertheless, further evaluation research of integrated programs is needed.

DO3: 3

The fight for maternal and child health is won in the community

Feven Tassew, Frehywot Eshetu, Sara Buchanan, Barbara Pose

CARE International, Sexual reproductive Health Program Unit, Ethiopia, Ethiopia; FevenT@care.org.et

Subtitle: - Approaches applied by CARE Ethiopia to mobilize communities to improve Child and maternal health and the theory to explain the successes -

Background/Significance

CARE International in Ethiopia is implementing Family Planning (FP) Programs and Maternal and Child Health Projects since the 1990ies using Community mobilization approaches to induce behavior change with significant success.

Hypothesis or Intervention/Activity Tested

Empowering communities and particularly women through targeted interventions are the key to improved child and maternal health in developing countries. Improved healthy behaviors (vaccination, breast feeding, child spacing) including timely health seeking behavior in communities where home delivery is the norm and people have limited access to health services are the key to reach MDG 4 and MDG5.

Methodology

The Health Program Coordination Unit conducted a workshop to review successes and approaches of current and previous health projects dealing with child and maternal health, family planning and HIV/AIDS. They identified the successful approaches and tried to develop an overarching framework / model in which change took place to inform future programming to improve maternal and child health and increase family planning (FP) use and HIV/AIDS awareness.

Data

The two most successful projects identified were the Farta Child Survival project implemented in Amhara Region between 2002 and 2007 and the Family Planning & HIV/AIDS projects implemented in Oromia Region between 1996 and 2009 in three phases.

Approaches used in the Child Survival Project:

Full coverage – every village had at least one – mother-to mother support group

Positive deviant mothers became facilitators of – mother-to-mother support groups and served as role models

Ethiopian Orthodox Church priests were trained on – Child and maternal health messages; they used biblical allegories to convince mothers that improved health behaviors were imperative.

Community Data Boards reporting on children who – completed vaccination and child death held all members of the community accountable for health outcomes.

Using authority for health promotion (priests) allowed – identification of community members
D03: Approaches predicting Eva in models

Hypothesis: 15.5% Intensive communities’ thus The in survey, Knowledge This aspect of modern work which generated 1977). The Royal Netherlands Embassy funded project improved access to Family Planning and HIV/AIDS services and increased Contraceptive Prevalence Rates (CPR) in the target areas by establishing a community distribution system. The CPR rose from 4% to 24.7 in Phase one, from 14.7% to 29.8 in phase two and from 15.5% to 27.7% in phase 3 (2006-2009).

Findings

The team identified the social cognitive learning theory / framework as the one which explains best the successes. The theory of Self-Efficacy maintains that success in behavioral change depends on outcome expectancy, or the belief that certain behaviors will have certain outcomes, and self-efficacy expectancy (Bandura, 1977). Perceived efficacy is often more critical to behavioral change than actual capabilities (Strecher, 1986) i.e. feelings of self-efficacy are useful in predicting the initiation of behavioral change.

The behavior change strategies applied by CARE projects took into account the traditional leadership structure, provided support to enhance self-confidence to change behavior of mothers, of women of reproductive age and of health promoters acting as role models. The key actors in the projects are the volunteers promoting new behaviors through interpersonal communication at house visits and modeling.

Community norms were challenged not only by the individual - the volunteer himself -but by the leaders who received training. In Amhara working with the priests eliminated the traditional healing system and the sense of fatality by transforming the priests into modern health promoters thus overcoming religious barriers i.e. towards vaccination. In Oromyia working with men as partners was challenging the gender norms on FP successfully.

New behaviors were instituted in time to bring about better tangible! health outcomes.

The projects are sustainable as the adopted new behaviors preserving children’s and mothers’ health and using FP for child spacing have replaced the old norm.

Knowledge Contribution or Lessons Learned

This aspect of expected outcome, the perceived ability to change in an environment where everybody seems to change as well (priest, leaders) is what made CARE’s projects strong.

Learning from role models (volunteers), learning by success (positive health outcomes) and learning with peers are the mechanisms which were key to communities’ behaviour change.

D03: 4 Integrating Family Planning into Postpartum Care: A Postpartum Family Planning Needs Assessment in Cap Haitien, Haiti

Eva Lathrop1,2, Youseline Telemaque1, Peggy Goodken3, Carrie Cwiak1
1Emory University, United States of America; 2Konbit Sante NGO, USA/Haiti; evalthrop@hotmail.com

Background: Haiti is widely recognized as the poorest country in the Western Hemisphere. The maternal mortality ratio in Haiti is 680/100,000. Increasing access to services that help avoid pregnancy are closely related to lower maternal mortality, thus demonstrating family planning as a method of primary prevention of maternal mortality. Recent census data from Haiti indicates 25% of sexually active women are using a method of contraception, 60% not using contraception expressed a desire to do so

The immediate postpartum period is focused on largely because this is a cohort of women who are likely interested in spacing or limiting future pregnancies, based on the most recent household survey data from Haiti showing a strong desire for birth spacing of at least 2 years among the majority of the women surveyed, yet a large number of women deliver a subsequent child in less than 2 years, indicating an unmet need for effective postpartum contraception.

Hypothesis: This study hypothesizes that women in the immediate postpartum period have unmet family planning needs and aims to evaluate the knowledge of and desire for contraception in postpartum women who have delivered at a large public hospital in Haiti, and to determine the level of knowledge and practices patterns of the providers in the realm of family planning (FP).

Methodology: This is a mixed-methods, qualitative and quantitative study. 6 focus-groups of immediately postpartum patients (n=33) were conducted in a large public teaching hospital maternity ward in Northern Haiti. Knowledge of, acceptance, and desire for contraception in postpartum women in Haiti was evaluated. A parallel assessment of knowledge, attitudes, and contraceptive practice patterns among maternity service providers at the same hospital was performed through 3 focus groups (n=22). Qualitative data was analyzed using MAXqda software for common themes and identified needs. Due to logistical feasibility, only a qualitative assessment of the providers was done.

The preliminary analysis of the patient focus groups was used to create survey questions. A structured questionnaire was piloted to 28 patients, a final survey was then generated and administered to a convenience sample of 250 immediately postpartum patients. The survey data was analyzed using STATA . Descriptive statistics were generated. Univariate and multivariate logistical regression calculations were then done for the outcome of interest: self-reported mistimed pregnancy.
Findings: Key patient focus group findings included the following:

• Most women expressed a desire to either space or limit their pregnancies, including women who had only one child.
• Economic hardship, fear of side effects and partners’ influence on contraception use decision making were cited as the most common barriers to initiating family planning methods.

Key findings from the provider focus groups included:

• Most providers stating that PP FP has traditionally been set as a low priority on a service focusing on emergency obstetrical and surgical care
• Uniform concern expressed over the volume of induced abortions and maternal morbidities and mortalities seen on the service, yet many feel these could be averted by improving PP FP services
• Most report long acting and permanent methods not offered unless patient has had many children

Key survey results: 72% surveyed expressed a desire for greater than 3 years spacing between births, yet 55% of those who’d had a previous birth stated they had not achieved desired spacing. 50% of current pregnancies were reported as unplanned, and 73% of women surveyed stated they do not want more children.

98% of participants expressed an interest in FP counseling postpartum, 90% planned to use FP postpartum, 80% wanted to choose a method prior to leaving the hospital, yet only 6% received FP counseling prior to leaving the hospital.

Mistimed pregnancy was defined as women who reported a shorter than desired interval between last birth and current birth. Women in all age groups over 30 were less likely to report a mistimed pregnancy (Adjusted OR 0.34, 95% CI 0.12-0.98). Women who did not use FP after their last delivery or who identified partners as unsupportive of their FP use were more likely to report a mistimed pregnancy (Adjusted OR 3.4, 95% CI 1.28-9.1, Adjusted OR 3.1, 95% CI 0.95-10.0, respectively).

Knowledge Contribution: There is a strong desire among patients studied to space and limit their childbearing, but a lack of information and education regarding method choices, an overwhelming fear of contraceptive side effects, together with economic hardship and societal norms impose insurmountable barriers, making it impossible for many women to reach their reproductive goals. Reproductive healthcare providers in this setting demonstrate great interest in attaining better education and experience with family planning, including informed and adequate postpartum implementation strategies. Efforts to design a systematic and comprehensive family planning program that can be integrated into the postpartum care services would help both patients and providers reach their goals.

D03: 5

A model of integration: Postpartum family planning through a community based maternal and newborn program

Salahuddin Ahmed1, Rasheduzzaman Shah2, Ishtiaq Mannan2, Angela Nash-Mercado2, Emma Williams2, Peter Winch2, Saidauddin Ahmed2, Ahmed Al-Kabir4, Catharine McKaig3, Abdullah Baqui2

1Johns Hopkins Bloomberg School of Public Health, Bangladesh; 2Johns Hopkins Bloomberg School of Public Health, Baltimore, MD; 3ACCESS-FP of Jhpiego; 4RTM International, Bangladesh; sahmed773@yahoo.com

Background/Significance
In Bangladesh, neonatal mortality remains high, and 37% of births occur at intervals less than 36 months; in Sylhet 57% of births occur at intervals less than 36 months. We describe an innovative intervention strategy for an area of rural Bangladesh of Sylhet district where over 90% of births occur at home, and demonstrate how promotion of pregnancy spacing and family planning can be effectively integrated into a community based maternal and neonatal intervention package for postpartum women.

Intervention/activity tested
The intervention consists of (i) systems and capacity strengthening by training of the health and family planning providers and facilitates their activities and, (ii) community-based advocacy and behavior change communication that is targeting pregnant and postpartum women and their families. Female community health workers, one per 4000 population, conduct one antenatal and four postpartum home visits during which they counsel families on pregnancy and newborn care, the lactational amenorrhea method (LAM), transitional methods and on healthy timing and spacing of pregnancy. Community Mobilizers, a pair - consist of male and female per 20,000 population, organize advocacy and community meetings with pregnant and postpartum women, their mothers-in-law, husband, community influential persons including religious leaders, their wives; and identify postpartum women to serve as role models on LAM.

Methodology
The project has a quasi-experimental design. It follows 4430 pregnant women in rural Sylhet district of Bangladesh longitudinally from pregnancy to 36 months postpartum at 8 time points – baseline during pregnancy and at 3 month, 6 month, 12 month, 18 month, 24 month, 30 month and 36 month after delivery. Data will be analysis in different times to measure knowledge on contraceptive methods and healthy timing and spacing of pregnancy, LAM and other method use rate and finally pregnancy interval and its effects on birth outcomes will be measure. The intervention has been implemented since December 2007 and will be completed by September 2011.

Findings
In intervention group, 49% of women at three months postpartum accepted any contraceptive method, compared to 30% in the comparison group (p<0.001).

Lessons learned
Family planning messages are well integrated with maternal and neonatal health program because of focus on health outcomes.

Expected outcomes include increased knowledge and practice of LAM, use of balanced method mix during extended postpartum period and increased pregnancy interval.

These results using data collected during the first one and a half years of the project will describe community knowledge and practices of using LAM and other modern contraceptives and also would reveal the impact of integrating FP component within community-based MNCH program.

E03: FP as a component of SRH

Time: Monday, 16 November 2009: 2:00pm - 3:30pm
E03: 1
Prioritizing FP/SRH and working in the new aid environment
Makane Kane
UNFPA, Mali; ortayli@unfpa.org

Both, the Paris Declaration on Harmonization and Alignment (March, 2005) and the Accra Agenda for Action (September 2008) have defined a set of principles and practices to be followed by both recipient countries and donors to make international aid more effective.

This presentation elaborates on the application of the new aid environment (NEA) principles in FP/SRH interventions aimed at prioritizing and reaching underserved groups. Particular emphasis is given to the following key principles of putting national health plans and budgets at the center of programs; strengthening national and local capacities; scaling up interventions; and, increasingly using and strengthening national systems. The focus of the presentation is to share the experience of UNFPA COs in various countries in strengthening SRH services and including services for adolescents working in the context of key NEA principles. It is stressed that regardless of the level of development of the country applying NEA principles has the potential to improve the quality of aid and ensuring long lasting development results.

The experience of UNFPA in supporting national policies aligned to national priorities, engaging in advocacy and policy dialogue, providing technical assistance, designing model interventions, assisting in scaling up effective SRH interventions at the national level, using national health system, and strengthening local capacity to offer SRH services is relevant to guide the work of other development agencies.

E03: 2
Family Planning as part of comprehensive SRH
Berhanu Legesse, Helene Amdemikael
UNFPA; ortayli@unfpa.org

Background/Significance
Investments in girls in ways that increase their age at marriage and first birth have a direct and powerful impact on all three elements of future well-being of the communities:
• Increasing the age at first birth is related to lower desired and achieved family size
• Increasing women’s bargaining power with partners to achieve safe timing, spacing of pregnancies, investments in both girl and boy children’s health and education
• Increasing the space between generations

Yet child marriage continues to be prevalent practice in many communities through the world hampering the health and well-being of girls and also their future families. Child brides face the risk of many adverse health outcomes including early child delivery, higher maternal mortality and morbidity, lower contraceptive prevalence rates, higher STI/RTIs, and infertility related to these.

State intervention/activity tested
A combination of interventions which target adolescent girls can be effective in decreasing child marriage and improving sexual and reproductive health, including contraceptive use.

This is a presentation on a comprehensive and an evidence based intervention, in a marginalized rural community in Ethiopia where child marriage is prevalent. Three groups of adolescent girls of two different age categories 10-14 and 15-19 years of age were targeted in this study. First group of girls were already married, second group of girls were not married, but were out of school, and third group were unmarried girls who were at school. A combination of interventions including conditional cash transfers, mentoring by older women, building of social networks, and literacy courses were used.

Findings
Through a rigorous baseline and end-line survey, spanning an 18-month period, the combination of context specific interventions demonstrated a delay in child marriage among both groups of young adolescent girls who were not married at the beginning of the intervention. The group of married girls also benefited from the interventions as there has been an increase in knowledge related to sexual reproductive health, HIV/AIDS and has led to uptake of contraceptives among. The positive results of the study has led to planning to scale-up the interventions into other rural areas in Ethiopia.

The programme is jointly implemented with the Ministry of Youth and Sports, The Population Council and UNFPA.

State lessons learned
It is possible to prevent child marriages and improve SRH knowledge of adolescent girls through a combination of context specific interventions such as building a social network, mentoring by older women and conditional cash transfers.

E03: 3
Financing FP/SRH programmes, and prioritizing them within National Plans and Budgets
Dia Timmermans
Independent Consultant; ortayli@unfpa.org

Financing RH activities is an important economic and social issue as it involves resource mobilization and the channeling of resources through the health system so as to effect better RH status of women and men. Up to now there has been a gap between the development of the reproductive/maternal health policy development/priority settings and the budgetary process. Policy planning takes place without consideration to resource constraints or implementation capacity.

The Medium Term Expenditure Framework (MTEF) is increasingly seen as a linking framework that allows expenditures to be driven by policy priorities and conditioned by budget realities. The MTEF sets budgets for a three year rolling period, which is revised annually, and consists of reconciling bottom-up estimates of the cost of implementing of government policies with top-down estimates of the resource envelope based on macro-economic stability. The monitoring of the flows of funds, i.e. the tracking of health expenditures, is an essential aspect of an assessment of the effectiveness of health financing schemes and the allocation of scarce resources. The financial information about who pays, how much and for what, that is generated by resource tracking is most effectively organized in National Health Accounts (NHAs).
UNFPA is engaged since 2000 in the national health sector processes and in at least 15 countries joining pooled funding mechanism with the aim to lobby for the full inclusion of SRH in the policy, strategies and into the government budgets.

**F03: Effective Programming and Service Delivery II**

**Time:** Monday, 16 November 2009: 2:00pm - 3:30pm

**F03: 1**

**An Innovative Approach to Increasing Uptake of Long-Term Family Planning Methods in Zambia**

Joselyn Neukom¹, Jolly Chilambwe²

¹Population Services International; ²Society for Family Health, Zambia; josselynneukom@msn.com

**Background:**

The total fertility rate in Zambia is estimated at 6.2 (7.5 in rural areas) Less than 1% of all married women in Zambia currently use a reversible long-term method (LTM) of contraception. In November 2008, Society for Family Health (SFH) – Population Services International’s (PSI) affiliate in Zambia launched a program to expand access to IUD and implant contraceptives. The innovative LTM service delivery model was designed based on an analysis of local opportunities and gaps identified in consultation with the Ministry of Health (MOH).

**Intervention Tested:**

Seconding LTM providers to high volume MOH sites.

**Methodology:**

SFH is improving access to highly effective LTM by reinforcing existing MCH capacity at select high-volume government health facilities. SFH’s LTM program model involves seconding well-trained, highly motivated and carefully supported Providers (who focus primarily on LTM service provision) to sites frequently visited by Zambian women with an unmet need for family planning. As of April 2009, SFH has placed teams of 1-2 Providers at 12 sites located across 3 of the country’s 9 provinces. Typically, these sites are either neighborhood health clinics located in congested, low-income urban neighborhoods or rural health centers serving large catchment populations. Government officials at central, provincial and district levels participated in the identification of potential facilities to host SFH Providers.

Eligibility to participate in the program requires a site be willing to provide the SFH Providers with exclusive access to a private examination room five days a week. Although not required, partner sites often also supply use of an examination bed, access to sterilization equipment and occasional use of consumable and contraceptive supplies. In exchange, SFH dispatches competent and committed LTM providers to the site. During recruitment, SFH emphasizes the ‘right’ attitude, a strong work ethic, and some prior family planning experience. Most SFH Providers had little experience with LTM services before joining the program. To ensure competency, SFH requires each provider to complete a 5 day competency-based training and to successfully insert 20 IUD clients under clinical supervision.

In addition to providing competent Providers to each site, SFH provides contraceptive and consumable supplies, basic equipment (including battery operated headlamps, plastic water buckets and LTM insertion/removal equipment.) SFH monitors and supports LTM Providers using various quality assurance (QA) activities including individual Provider assessments, in-depth interviews with clients served by SFH, and through careful review of MRS forms and supply requisition forms.

Another key to the success of this program is evidence-based interpersonal demand creation. Using a flipchart designed to emphasize the distinct benefits of LMTs, SFH Providers conduct daily “sensitization talks” to women waiting for Maternal Child Health (MCH) services. The flipchart was developed using results of in-depth interviews conducted among Zambian women who are satisfied LTM users. These concentrated and focused interpersonal sessions are a cost-effective way to reach large groups of women who are likely to have an unmet need for LTM services. Roughly 1 out of every 5 women reached through the ‘sensitization’ technique becomes a satisfied contraceptive user.

**Findings:**

In its first six months, the program has served 7,200 women with a long-term method of their choice. Of these, 39% chose the IUD. To put this achievement in context, the number of IUD clients served by SFH teams in the first six months represents roughly 73% of the total number of IUDs distributed nationwide by the MOH during 2008. Most LTM clients served by SFH to date are young women between the ages of 20 and 29. More than 60% have less than a primary education. Removals as a percentage of insertions are low and have decreased. Only 2.3% of all implant clients and 1.5% of all IUD clients requested removals in April 2009—an indication that the program is providing high quality counseling to ensure informed choice.

**Lessons Learned:**

Advantages of this model include the ability to quickly reach large numbers of women with minimal investments in infrastructure. Implementation and scale-up can occur cost-efficiently, especially in a context where the implementing organization has strong relationships with MOH at central and local levels. Another key advantage of this model is quality. Control over provider recruitment, training and management maximizes the likelihood that service delivery protocols are followed consistently. Given that SFH Providers are employees, SFH has multiple mechanisms which can be used to incentivize or enforce consequences based on Provider performance. Client follow-up is strong since clients can return to the same facility in cases of complication or other needed follow-up care. Lastly, this model is targeted to women who need LTM services most, and therefore equity is another benefit. Limitations to this model include coverage and sustainability.

**F03: 2**

**Contraceptive initiation simplified: Health providers experience using family planning checklists**

Beatrice Atieno Ochieng¹, Violet Bukusi¹, Solomon Marsden¹, Rick Homan¹, Trinity Zan², Eva Canoutas²

¹Family Health International, Kenya; ²Family Health International, North Carolina, USA; bochieng@fhi.org

**Background**

Health providers often deny contraception to non-menstruating clients, fearing possible harm to a potential pregnancy. However, research shows that this is a needless barrier. Provider screening checklists developed based on World Health Organization medical eligibility criteria can be used to rule out pregnancy and determine whether a client may safely and effectively use the contraceptive method of their choice. In Kenya, a trial showed that a simple checklist ruled out
pregnancy for 88 percent of new clients, with more than 99 percent accuracy. In Guatemala, Mali and Senegal, denial of the desired method due to menstrual status decreased significantly from 16% to 2%.

The checklists are a quick reference material for providers, increase their confidence and improve provision of contraceptives to non menstruating women seeking to initiate the contraceptive method of their choice at the time of their visit.

This paper presents the success in adaptation and utilization of four checklists including; “How to be Reasonably Sure a Client is Not Pregnant” and three other method-specific checklists to enhance FP service provision.

Intervention

The easy-to-use screening checklists can be used by both clinical and non-clinical providers to rule out pregnancy among non-menstruating women and to initiate the use of three popular contraceptive methods: combined oral contraceptives (COCs), injectables (DPMA and NET-EN) and the copper intrauterine device (IUD).

The checklist for ruling out pregnancy is composed of questions to test the possibility of one being pregnant based on menses, lactation and sexual activity following last menses. The method specific checklists contain questions that are used to establish pre-existing conditions that would make the contraceptive method unsuitable to the client.

Methodology

In 2007, the Kenya Family Planning technical working group chaired by the Division of Reproductive Health (DRH) reviewed the checklists and aligned them to the Kenya Family Planning guidelines before co-branding with Ministry of Health logo and adapting them for use in Kenya. Subsequently distribution and capacity building efforts including supportive supervision were initiated to increase the use of the checklists. To date, 2,590 providers and program managers have been trained and 4,885 sets of provider checklists have been distributed to individuals and health facilities.

In June 2008, a utilization assessment was conducted to document the availability and usage of the checklists and perceptions towards them using semi-structured questionnaire. A total of 90 questionnaires were sent via mail to service providers, policy and program managers in all eight provinces in Kenya. Participants were then contacted by telephone to ensure receipt and provide further guidance where needed.

Findings

At the time of the assessment, 6 out of 8 provinces had checklists either posted on the wall in the counseling room or on the provider’s desk. 11% (509) of health facilities offering family planning services confirmed having provider checklists and of these 95% (486) use the checklists on a regular basis.

Overall, providers and program managers found the checklists useful; 87.5% indicating the checklists are very useful and 12.5% somewhat useful. The checklists on how to rule out pregnancy and that on DMPA were rated as very useful by all the participants.

Program managers in Central, Nairobi and Coast provinces reported that the checklists were handy, user friendly and rich in information necessary to guide the service providers and ensure that no client goes home without counselling and a contraceptive method of their choice. Providers also indicated that the checklists were portable and addressed possible medical barriers to contraceptive provision. The challenges faced by the program managers included ensuring adequate distribution, lack of systems for tracking distribution of checklists, capacity building of providers on the checklists, and a lack of adequate resources to conduct frequent supportive supervision.

Lessons learned

Incorporation of provider checklists in family planning training and capacity building sessions was an effective way of ensuring quick dissemination of the checklists. Collaborating with the Ministry of Health to review and co-brand the checklists increased stakeholder buy in. The checklists should be regularly updated as information becomes available since they serve as quick reference points and should be distributed alongside Family Planning guidelines. The incorporation of the checklists into the DRH supervisory tool encourages their use, reminds the supervisors to provide support for their use and helps identify health facilities in need of the checklists. To ensure adequate and equitable distribution, tracking of checklists distributed needs to be strengthened.

F03: 3

Current Practices of IUD Insertion Among Physicians in Central America

Isolda Fortin1, Benjamin Nieto-Andrade2, Pedro Jaime3

1Population Services International, Guatemala; 2Population Services International; 3Population Services International; bandrade@pasmo-ca.org

Background/Significance

PSI is a global program to improve the reproductive health of millions of women in 14 countries in Asia, Africa and Central America. It is currently focusing on increasing the use of long-term contraceptive methods, specifically IUDs and implants, and providing health services through a net of private doctors, NGO’s, and governmental health clinics. In the case of Central America the percentage of sexually active women using IUD is low, due in part to the limited options of contraception offered by the health system. Knowing the current barriers and drivers of IUD among providers of different sectors will allow designing a health program that actually provides women with equal options of contraception.

Research Objectives

This study seeks to gain an in-depth understanding about the drivers and barriers in providers of Central America to including the IUD as part of their family planning practice. The specific objectives are to know the positive and negatives features conferred by providers to the IUD as compared to other modern family planning methods and whether the provision of the IUD fits the current practice and business model of providers.

Methodology

A total of 72 in depth interviews were carried out between March and April of 2009 in Guatemala, El Salvador and Nicaragua with male and female physicians from NGOs, Public and Private Sector Clinics. 36 interviews were carried out with physicians who insert IUDs in their everyday practice and 36 interviews were carried out with non-adopting providers. Among the main topics covered were: past and current trainings on IUDs; experiences of family counseling training and, if applicable, with IUD insertion; and institutional incentives or barriers for IUD insertion.

Findings

Although physicians recognized positive aspects of the IUD, such as effectiveness and fewer secondary effects as compared to other modern methods of contraception, they also referred to professional and institutional barriers for its implementation. Among these barriers, physicians mentioned lack of adequate training, since neither universities nor ministries of health focus on this method. Most of the trainings on IUD insertion occur in the NGOs, but physicians
working in the public or private sectors do not have access to such trainings. As a consequence of this lack of training, some physicians refer to IUDs as an abortive method, an idea that derives from their own personal religious beliefs rather than from scientific data. Other doctors report fears of negative consequences to their own professional status if problems arise due to their lack of skills to perform a good IUD insertion.

Physicians also referred to limitations of space and equipment when they need to insert IUDs: they don't have private spaces to adequately check women, they lack promotional or educational material, and they find it difficult to obtain IUDs. Although physicians are supposed to counsel women about all modern methods of contraception, in practice they find that there is no equity between the information provided and the supply of all methods, with IUDs being among those more difficult to obtain.

Results also show differences in facilities for IUD insertion depending on where the physician works. While physicians in the public sector found themselves with high loads of work, few incentives and time to insert IUDs, physicians of NGOs and private sectors were in a relatively more privileged position. The latter were recipients of constant trainings and dedicated more time to each patient, as these were seen as important clients to be kept happy.

Research and Program Conclusions

An effective program in Central America to enhance a balanced supply of IDUs needs to provide training to physicians so they can adequately orient patients on the benefits and disadvantages of the method. This training most likely will be well received by physicians since they perceive any type of training as a benefit for their curriculum and as a tool that will put them in advantage when compared to other physicians. Efforts should also focus on making sure that family planning becomes part of the curricula of the medical and nursing schools with specific emphasis on IUD insertion.

To enhance IUD insertion in the public sector, the program should calculate the real time that must be invested per patient to avoid overloading the already busy work of physicians. The program should also look for agreements at the institutional level to make feasible the adequate counseling and follow-up of women who decide to get an IUD. The agreement can include the provision of IUDs free of cost or at reasonable price, the compensation for doctor’s time as they would normally receive it in other circumstances and the supply of adequate space to assure the privacy and comfort of women. Finally, the program should also provide IUD kits at a reasonable price, and if it is possible, free of cost to physicians and clinics that request them.

F03: 4

How well do national family planning guidelines from Africa adhere to international guidance?

Lucy C Wilson1, Erin McGinn2, Irina Yacobson2, John Stanback1

1Family Health International, United States of America; 2EngenderHealth, United States of America; lwilson@fhi.org

1. Background/Significance

The World Health Organization collaborates with international experts to systematically review and assess the latest evidence on contraception and reproductive health. WHO has published Medical Eligibility Criteria for Contraceptive Use (3rd edition, 2004), and Selected Practice Recommendations for Contraceptive Use (2nd edition, 2004), in an effort to provide guidance to national family planning/reproductive health programs.

When properly disseminated, with adequate training and supervision, national evidence-based service delivery guidelines can improve family planning practices, and ultimately, reproductive health. But the first step is the development (or updating) of these national guidelines. When they are not current, the quality of reproductive health services will be compromised.

2. Program: State intervention/activity tested

To compare the content of national family planning service delivery guidelines from various Sub-Saharan African countries with the 2004 World Health Organization Medical Eligibility Criteria and Selected Practice Recommendations for Contraceptive Use and other international recommendations.

3. Methodology (including location, setting, period, analysis approach)

National FP/RH guidelines from 13 Sub-Saharan African countries (published between 1997 and 2007) were reviewed and assessed against 21 criteria by a study team of four FP/RH professionals: a researcher, a medical doctor, a research utilization expert and a monitoring and evaluation specialist. The 21 criterion included structuring of services (including CBD, pharmacists), provision of COCs (time of initiation, advance provision), ECP timing, DMPA grace periods, IUD removal with PID, missed pill instructions, vasectomy time to effectiveness, and the general accurateness of who can or cannot use which methods based on pre-existing medical conditions.

Rankings were given on a scale of 0 to 3 for each criterion in each set of guidelines, with 3 indicating accurate/consistent with international recommendations, and 0 indicating either out-dated, inaccurate coverage, or exclusion of the topic. Scores of 1 and 2 represented partial credit, either because coverage of these topics was internally inconsistent, incomplete, and/or adhered only partially to standards of medical accuracy and restrictiveness.

4. Data (if relevant)

5. Findings

Malawi’s guidelines, published in 2006, had the highest score, at 48 of a possible 63. The lowest score, 20, came from Ethiopia, which had the oldest set of guidelines, from 1997. The median score was 34, with a range of 20 to 48.

In seven guidelines, the information on medical eligibility accurately reflected all four categories of WHO MEC guidance. Five countries neglected to address the contraceptive use recommendations in light of the HIV epidemic and the remaining eight all diverged somewhat from WHO MEC. All countries mentioned community based provision of FP. Twelve allowed for CBD of pills; only one mentioned CBD of DMPA. Pharmacists are largely neglected in national guidelines, despite their growing role in FP provision in many countries. Unnecessary limitations on the advance provision of OCs are the norm and almost half of the guidelines did not mention ECPs. A number of countries did not address early/late DMPA injection periods, and four out of 13 had missed pill instructions close to WHO recommendations. Five countries correctly specified that vasectomized men should use a back-up method for three months. For women with an IUD in situ who develop PID, WHO recommends she be treated without removing the IUD if the client wishes to continue using that method. However, the majority of guidelines reviewed were not critical on this topic. With a composite score of only 13 out of a possible 39, this was one of the lowest scoring criteria reviewed.

On a positive note, restrictions on the use of the IUD based on age and parity had almost disappeared, and an historically common barrier to accessing contraception – the need to start hormonal contraception while menstruating (as proof that the woman is not pregnant) – is slowly being phased out of FP/RH guidelines; nine guidelines specifically mentioned pills can be initiated at any time, provided the client is reasonably sure she is not pregnant.

6. Program: State lessons learned

The authors acknowledge clinical practice often varies from prescribed guidance and even with evidence-based national guidelines in place, outdated medical training may impede a provider’s accurate provision of FP. Likewise, the lack of actual physical access to guidelines by providers can be an issue. A great deal of
effort and money goes into developing dozens of national guidelines that, in essence, are quite similar. The authors found a significant diversity among the 13 guidelines reviewed with respect to ease of use, content, and comprehensibility. The authors recommend that the WHO develop a standard template for national service delivery guidelines that countries can adapt, while national governments, donors, and other stakeholders should allocate resources to ensure guidelines are regularly updated, disseminated actively, and available physically and electronically to providers and program planners.

F03: 5
Removing barriers to DMPA continuation: Field-testing a provider job aid in Senegal
Kate Rademacher1, Boniface Sebikali2, Lucy Harber3, Babacar Gueye4, Fatou Ndiaye2, Carol Cisse5, Joy Noel Baumgartner6
1Family Health International, United States of America; 2IntraHealth; krademacher@fhi.org

1. Background/Significance
Progestogen-only injectable contraceptives, including Depot Medroxyprogesterone Acetate (DMPA) and norethisterone enantate (NET-EN), are among the most popular forms of modern contraception in sub-Saharan Africa. However, the effectiveness of injectables is diminished due to high discontinuation rates. While most research has focused on reasons for clients’ intentional discontinuation, a recent study in South Africa revealed that many women using DMPA and NET-EN who wanted to continue using the method were being discontinued by their providers because they returned late for their re-injections. In the Eastern Cape of South Africa, approximately half of the women were late for their injections; nearly one-third were late by two weeks or less; and a substantial portion of those within the approved grace period were denied a re-injection. Many were not given an alternative contraceptive method, or were told to return to the clinic only after they had begun menstruating (which may take up to several months with long-term use of injectables); thus, these women were left at risk of unintended pregnancy during this time. Through a follow-up study currently underway in the Eastern Cape, providers were trained on a new job aid which was designed to help them better manage clients’ DMPA and NET-EN re-injections. Preliminary results indicate that the introduction of the job aid increased the number of clients who received re-injections among those who returned both within and outside of the approved grace period.

In 2008, the World Health Organization (WHO) changed its recommendations regarding the timing of the re-injection grace period for DMPA. A client can now receive a re-injection if she is as many as two weeks early or four weeks past her scheduled re-injection date without ruling out pregnancy.

2. Program: intervention/activity tested
In order to inform the development of DMPA and NET-EN re-injection job aids for global dissemination, Family Health International and IntraHealth established a collaboration to field-test the DMPA tool at 12 sites in Dakar, Senegal. Like many countries, Senegal’s current reproductive health policies are not based on the 2008 WHO guidelines, and thus do not reflect the approved extended grace period for DMPA. In 2009, Senegal’s Ministry of Health (Ministère de la Santé et de la Prévention Médicale) gave approval to field-test a version of the DMPA re-injection job aid that is based on the tool tested in South Africa and which reflects the 2008 WHO guidelines. The job aid is designed to help providers determine the appropriate response when clients return for re-injection both within and outside of the approved grace period. The objective of the field-testing process was to better understand the perceptions of intended users (providers) regarding the readability, usability, and applicability of the job aid (i.e., clarity of language and illustrations, sequencing of steps, appropriateness of the media, etc.) in order to revise and finalize the job aid for global dissemination. In addition, providers’ willingness to change clinical practice to align with the 2008 WHO guidelines was assessed.

3. Methodology (including location, setting, period, analysis approach)
Twenty-one clinicians from 12 sites in Dakar were trained on the DMPA re-injection job aid in April 2009. Providers used the job aid for approximately one month. Follow-up interviews with 15 participating clinicians were used to assess their perceptions of the job aid. In addition, interviewers asked clinicians to respond to two hypothetical scenarios involving clients returning for re-injections. Responses helped to assess whether the job aid was being used correctly. Providers were also asked if they would recommend that Senegal’s national family planning guidelines be revised to reflect the 2008 WHO guidelines.

4. Findings
Interviews began May 20, 2009 and will be completed by June 15, 2009. Preliminary results from the field-testing process indicate that providers need more in-depth training on the expanded DMPA grace period than originally anticipated. Most providers had a positive reaction to using the tool. Some recommended simplifying the tool, using a larger font, and either changing or eliminating a calendar graphic. All providers were willing to change their clinical practice to align with the 2008 WHO guidelines.

5. Program: state lessons learned
Introduction of the DMPA and NET-EN re-injection job aids has the potential to increase continuous use of injectable contraception among clients who would have otherwise been denied a re-injection for returning late. In particular, the job aid can help prevent unintended pregnancies among clients who would have been sent home without any alternative method of contraception, or told to return to the health facility only after the return of their menses. Responses from providers in Senegal will inform revisions of the job aid, which will then be finalized and distributed globally. In addition, the recommendations and experiences of providers will be used to encourage policy-makers to review and update national guidelines in Senegal and other countries to reflect current guidelines regarding injectable contraception.

P2: Poster Session 2: FP Trends and Determinants and Linkages with HIV

P2: 1
Sex-Refusal Skills and Safer-Sex Practices of Women in Osun State of Nigeria
Bayode Isaiah Pопoola
Obafemi Awolowo University, Ile Ife, Nigeria, Nigeria; bayodep@yahoo.com

BACKGROUND/SIGNIFICANCE:
Adverse reproductive health outcomes such as unintended pregnancies and sexually transmitted infections (STIs), including HIV, are significant reproductive health challenges of contemporary Nigerian women. Available statistics indicate that only 31% of Nigerian women consistently use a modern family planning method. Consequently, about 6.8 million pregnancies occur each year in Nigeria out of which 20 percent are unintended (Guttmatcher Institute, 2006).

In contemporary Nigerian societies, traditional gender roles stipulate that a man should initiate sexual activity while the woman is expected to respond positively. Also, patriarchal ideologies exist, which prevent women from asserting their sexual rights by insisting on the use of contraceptives in a sexual relationship. With low level of contraceptive use, it is significant that women should equip themselves with a repertoire of strategies for encouraging unsafe
sex and be able to clearly communicate such to their partners. Inability to do this may expose them to the risk of unintended pregnancy, STI’s, sexual violence and other negative sexual experiences. Thus, an investigation into women’s sex-refusal skills is of considerable value for women in societies like Nigeria where cultural and traditional values do not promote contraceptive knowledge and use.

**HYPOTHESIS or INTERVENTION/ACTIVITY TESTED:**

The study examined the sex-refusal strategies used by Nigerian women in negotiating safer sex with their partners. The underlying assumption is that since contraceptive use is low among Nigerian women, they would adopt effective sex-refusal skills to be able to negotiate safe sex. Specifically, the study was designed to determine the methods used by Nigerian women to practice safe sex in circumstances where contraceptive use is low. The study also determined the influence of variables such as age, marital status and level of education on women’s sex-refusal skills.

**METHODOLOGY:**

Study participants were 354 women selected by convenience sampling from two urban towns in Osun State, Nigeria. A survey questionnaire, which was pilot-tested on a sample of 75 women to ensure content validity, readability and ease of understanding, was used for data collection. Reliability analysis showed that the instrument had moderate internal consistency (Cronbach’s alpha 0.69). Respondents were guaranteed complete anonymity and confidentiality with respect to their written responses. Data analysis was done using descriptive and chi-square statistics.

**DATA/FINDINGS:**

All respondents reported the use of multiple sex-refusal strategies. The most-widely used strategy was bargaining (73.7%). This was followed by disengagement (58.7%) and begging (56.3%). About 19% of respondents insisted on condom use, 10.8% engaged in outer sex, 9.6% physically resisted their spouses from having unsafe sex while 8.4% consented to their spouses taking another sex partners as a way of avoiding unsafe sex. However, 49% of respondents reported that at one time or the other they had submitted helplessly to their spouses having sex even when they considered it unsafe. On factors which might influence respondents’ sex-refusal skills, chi-square statistical analyses revealed that age was significant when women adopted the strategy of consenting to their husbands’ decision to take another sex partner ( \( z = 11.63, p < 0.05 \)) and when they had to engage in outer sex ( \( z = 9.36, p < 0.05 \)) to prevent pregnancy and sexually transmitted diseases. The proportion of women who consented to their husbands having another sex partner was greater among older than younger women.

**KNOWLEDGE CONTRIBUTION OR LESSONS LEARNED**

The study demonstrates that Nigerian women engage in unsafe sex practices and that they are not adequately equipped to refuse unsafe sex from their partners in spite of their low level of contraceptive use. The study considers lack of effective sex refusal skills as a major cause of women’s vulnerability to unsafe sex and, by logical extension, susceptibility to HIV/AIDS.

**P2: 2**

**Understanding HIV-positive Women’s Barriers to FP/RH Services: PLHIV and Provider Knowledge and Experiences in Kenya**

**Beatrice Okundi**

Health Policy Initiative, Kenya; bokundi@futuresgroup.com

1. **Background/Significance**

Women’s family planning/reproductive health (FP/RH) needs do not cease when they become HIV positive. Women living with HIV should have the right to make informed decisions about whether to have or not have children, or to delay childbirth. These positive women are in need of high-quality, non-discriminatory FP/RH information and care. However, a growing body of evidence suggests that HIV-positive women’s FP/RH needs have been neglected. In Kenya, HIV prevalence among women (15-49) stands at 9.2 percent (Kenya AIDS Indicator Survey [KAIS], 2008). The 2008 KAIS report indicates that about 50 percent of HIV-positive women have an unmet need for FP. A study by the Center for Reproductive Rights and FIDA-Kenya (2008) indicates that many Kenyans assume an HIV-positive woman should not be sexually active. Furthermore, many HIV-positive women report provider hostility and judgmental attitudes when they reveal that they are sexually active and would like information about FP. Women and providers alike also report that providers lack clear information and guidelines on recommending FP options to HIV-positive women, which affects their plans to have, delay, or not have children. To address this issue, the USAID Health Policy Initiative (HPI) assessed knowledge and stigma and discrimination (S&D) related to HIV-positive women’s FP/RH needs in Kenya.

2. **Research: State main question/hypothesis**

Program: State intervention/activity tested

To inform the design and piloting of a training module for healthcare providers on S&D, HPI conducted research with PLHIV and providers on knowledge and experiences related to FP/RH. HPI was particularly interested in determining how S&D by service providers affects HIV-positive women’s unmet need for FP and influences their experiences with RH services.

3. **Methodology (including location, setting, period, analysis approach)**

The team used a semi-structured guide in a group discussion format with PLHIV support groups associated with health clinics in four sites within the Kirinyaga District in the central province of Kenya. Both women and men took part in the discussions, the majority being women, for a total of approximately 50 participants. A group discussion was also held with 30 men and women from national PLHIV networks.

The team also distributed a confidential, self-administered, anonymous questionnaire among FP/RH providers at three health clinics within the Kirinyaga district to gauge provider work environment, knowledge, and attitudes. A total of 19 health service providers took part in the assessment. Data were collected between November and December 2008.

4. **Data (if relevant)**

5. **Findings**

HIV-positive women understand FP in general, but often have misconceptions due to lack of information or inaccurate information from healthcare providers. Misconceptions 1) limit women’s contraceptive options (e.g., emphasis is on condom use); 2) might deter FP use or treatment (e.g., misunderstanding the interaction between FP methods and ART); and affect childbearing decisions (e.g., healthcare providers often supply misleading information about mother-to-child transmission, telling women they must have CD4 counts of 500 or above to safely bear children, and that babies have a 50 percent chance of being HIV negative). Furthermore, HIV-positive pregnant women may stop attending HIV clinics when they become pregnant, and go to general antenatal clinics where their status is not known, compromising their overall care. Discussants reported high levels of S&D in maternal and child health/FP clinics and maternity wards, in comparison to comprehensive care clinics. Less than half of providers report being trained on FP/RH services for HIV-positive clients, revealing a potential
lack of knowledge that can affect access to and quality of care and information for HIV-positive women. While the majority of providers believe PLHIV have the right to receive FP/RH counseling, nearly a third of providers reported that they do not counsel HIV-positive clients on FP/RH.

6. Research: State knowledge contribution

Program: State lessons learned

Findings indicate that healthcare providers often share limited or incorrect FP/RH information with HIV-positive women. Lack of training results in an incomplete understanding of FP methods for HIV-positive women and ways to reduce the chances of mother-to-child transmission in women who are pregnant or wish to become pregnant. Stigma and discrimination can be caused by the lack of knowledge coupled with personal attitudes related toward HIV. Healthcare providers’ and positive women’s beliefs and knowledge of FP/RH matters can affect implementation and scale-up of other programs and interventions, such as those focusing on prevention or treatment, if for example, positive women will discontinue ART to take FP. Recommendations to address these issues include:

- Up-to-date, periodic training on FP/RH issues for HIV-positive women and provision of integrated FP/RH/HIV services;
- Sensitization training for providers to improve awareness of HIV-positive women’s rights and the impact of stigmatizing and discriminatory behavior; and
- Linkages with PLHIV networks to share up-to-date information and better understand the needs of PLHIV.

Based on this research, HPI will design and pilot a training curriculum aimed at reducing S&D by healthcare providers related to HIV-positive women’s FP/RH needs.

P2: 3

Contextual factors related to contraceptive use among women in Offinso district, Ghana

Easmon Otupiri1, Juliana Bosomprah2, Roderick Larsen-Reindorf3, Agatha Bonney1

1Kwame Nkrumah University of Science and Technology-School of Medical Sciences, Ghana; 2Komfo Anokye Teaching Hospital; 3Ghana Health Service; easmono@yahoo.com

Preamble:

The negative effects of high fertility on women and their children as against the beneficial effects of fertility-control have been well described. Though an increase in contraceptive-use has been recorded worldwide, the increased use (any method) in Africa has been uninspiring. The rate of modern contraceptive-use by married women in Ghana tells the story. Knowledge, accessibility and socio-economic factors inform contraceptive-use.

Offinso district has consistently recorded a contraceptive prevalence rate (CPR) for all methods among all women lower than the regional average; 7.6% (2004), 15.8% (2005) and 17.9% (2006). The district target of 30% has never been achieved.

Hypothesis/Intervention/Activity Tested

We sought to describe contextual issues that affected ever use of contraceptives among women aged 20-48 years.

Methods

The study was carried out in Offinso over the period August – December, 2008. We collected data from a sample of 330 women aged 20-49 years. We used EPI STAT Calc version 4.0 (CDC, Atlanta) to determine the sample size based on a district population of 155,379, a CPR of 12% as the population parameter with an 8.94% lower margin expected, 0.5 margin of error at 95% CI. We used EpiData 3.0 for data entry and SPSS version 15.0.1 for analyses. Ethical clearance was provided by the Internal Review Board of the Offinso District Health Administration. Respondent verbal informed consent was obtained before data were collected.

Results

The average age of respondents was 30.8 years (SD 6.86 years); the age range was 20-48 years. A third (30.9%) had some form of formal education, 85.5% were in some form of employment and more than 80% had a sexual partner at the time of the survey; in 57.3% of those with a sexual partner, the partner was her husband.

Nearly half (57%) desired 1-4 children, 81% had ever been pregnant, 58.1% had had a child before age 19, 80.6% reported that their last pregnancy was unplanned, 63.0% had a birth interval of 2 years plus and the outcome of last pregnancy was a live birth for 90% of the women and 27.9% had ever used a contraceptive method.

Fewer children desired, less frequent pregnancies and longer birth intervals were significantly associated with ever using a contraceptive method (p=0.001), while age at first pregnancy (p=0.10) and outcome of last pregnancy (p=0.08) were not significantly associated with reports of ever use of any contraceptives. We found that higher age (p=0.001), higher educational level (p=0.001), being employed (p=0.001) were all significantly associated with any contraceptive use. Women’s income spent per day, being sexually active and being married were not significantly associated with contraceptive use.

Ever-use of any family planning (FP) method was reported by 29% of those who had heard about contraceptives (n=316). Commonly used FP methods were: pill (66%), injectables (17%), traditional (10%) and sterilization (7%). The most commonly cited reasons for non-use were: ‘fear of side effects including infertility’ (70.1%) and ‘desire to have children’ (19.6%).

Nearly all women (96%) had heard about contraceptives mostly through the radio; the most commonly known modern methods identified were pills (67.1%), injectables (57.3%), condoms (50.9%) and IUD (45.9%). Only 41% had ‘good knowledge’ about contraceptives – age, educational level, occupation, being sexually active and marital status were not statistically associated with levels of knowledge.

A majority (85.4%) spent less than 40 minutes to access a health facility but almost four-in-five (81%), reported contraceptive unavailability in the facility. The District Health Management Team reported frequent FP commodity stock outs. Among the 92 ever-users, (77%) reported health staff friendliness.

Few (28%) respondents reporting discussing contraceptives with their sexual partners. Contraceptive availability (p=0.001) and discussion with partner (p=0.001) were strong predictors of contraceptive-use while time to nearest facility was not associated with use (p=0.08).

Knowledge contribution

Reaching optimum levels of contraceptive use to positively influence health and economic growth is important for Ghana. In the Offinso study as in other studies in Ghana, a high level of unplanned pregnancies was reported suggesting persistent unmet need. FP commodity stock outs should cease. Correct information about contraception is needed to address fears of infertility. The factors that have been shown to influence contraceptive use must be addressed if Ghana is to attain respectable levels of contraceptive-use with their attendant benefits of health and economic growth.
**P2: 4**

**Condom and HIV Prevention among Indian Youth**

Ulirimi Venkata Somayajulu, Tilak Mukherji
Sigma Research and Consulting, India; somayajulu.uv@sigma-india.in

**Background**

In India youth in the age group of 15-29 years comprise almost 25 percent of the country's population; however, they account for 31 percent of AIDS burden. This clearly indicates that young people are at high risk of contracting HIV infection.

Physiologically, young people, particularly girls, are more vulnerable to STIs than adults; Gender imbalances, societal norms and economic dependence contribute to this risk, while lack of access to correct information, tendency to experiment and an environment which makes discussing issues around sexuality taboo adds to their vulnerability.

Young women are biologically more vulnerable to HIV infection than young men – a situation aggravated by their lack of access to information on HIV and even lesser power to exercise control over their sexual lives. Early marriage also adds to the risk in India, where almost 50 percent girls are married off by the time they reach 18 years of age.

**Objectives**

This paper makes an attempt to assess the role of condom in HIV and STI prevention among the Indian youth. It also gives a brief review of the condom promotion strategies adopted as part of the National AIDS control Programme and lists out the programme implications.

**Data**

The paper makes use of the data from the National Behavioural Surveillance Survey (BSS) carried out by NACO (2006) among youth of 15-24 years across the different Indian states with a sample size of 78,916. The analysis is carried out at national as well as state level in terms of indicators such as awareness, of condom and its role in HIV prevention, easy availability of condom, accessibility of condom, condom use with different types of partners etc. The analysis is carried out by gender, age (15-19 yrs and 20-24 yrs) and residence.

**Findings**

Though condom use in India has been promoted since the 1960s under the National Family Planning Programme for prevention of unwanted pregnancies, its promotion received major impetus and significance with the outbreak of HIV. With nearly 86 percent HIV transmission through unsafe sex in the country, NACO advocates and promotes condom use as a safe sex practice for prevention of STI/RTI and HIV, in addition to protection from unwanted pregnancy.

Currently, about 2.25 billion condoms are distributed per annum and so as to achieve the target of 3.5 billion condoms every year by 2010, NACO has adopted condom promotion at three levels: free supply in STI/RTI clinics, by way of targeted interventions through social marketing, involving government medical machinery at the state level, and by promoting and facilitating commercial sales through hitherto unconventional sales outlets, and raising their number to three million by 2010 from the existing one million.

More than four fifth of the youth reported awareness of condoms with higher awareness in urban areas and among males. Of the youth aware of condom, 15% do not know its role in HIV prevention with the awareness being lower in rural areas and among females. Easy availability of condom was reported by 92% of the youth aware of condom, while 85% reported condom procurement within 30 minutes.

At the national level, the median age at sexual debut was 18 years for males as well as females in rural and urban areas. At the national level 8% of the youth had sex with non regular partner in the 12 months before the survey. Among these youth, 62% used condom during last sex with non regular partner. This proportion increased from 52% in BSS 2001. Consistent use of condom with non regular partners in the 12 months before the survey was reported by 47% of the youth, against 34% recorded in BSS 2001.

**Lessons Learned/Implications**

The higher levels of condom awareness, availability and use can be attributed to the efforts made under the NACP. However, rural areas and female youth need greater attention to improve awareness and accessibility of condoms. Specific initiatives to be considered include:

- Ensure condom use during sex with non-regular partner
- Increase the number of condoms distributed by social marketing programmes.
- Increase the number of free condoms distributed through STI clinics so as to reach the people who are at highest risk of acquiring or transmitting HIV.
- Increase access to condoms, especially in rural and remote areas
- Provide condoms through vending machines
- Strengthen the social marketing programmes for condom promotion
- Improve communication on condom so as to make awareness universal

**P2: 5**

**Determinants of Contraceptive Use among HIV Infected Women attending Care in an Urban Center**

Fred Ssewankambo, Carol Namugwya, Gertrude Namale, Ibrahim Lutalo, Andrew Kamburu
Infectious Diseases Institute, Uganda; ssewaf@yahoo.com

**Background**

As the health of those under HIV/AIDS care improves on antiretroviral therapy (ART), many resume sexually active lives. With increased sexual risk behavior and low utilization of contraception, many end up with unintended pregnancies.

Main objective of study was to estimate prevalence use and investigate determinants of contraceptive use among HIV infected women attending urban HIV care.

**Methodology**

We used data from a cross-sectional survey conducted in March 2007 among HIV positive women (18-49years) who were attending HIV/AIDS care at Adults Infectious Disease Clinic (AIDC). Multivariate logistic regression analysis was ran to investigate the determinants of contraceptive use among HIV positive women in Care.
Findings: Among 493 respondents, 64% were currently married with 88.4% having formal education and 54% in gainful employment. Two hundred and seventy four (55.6%) respondents were sexually active (had sex in the last 3 months) and 179 (65.3%) were using at least one modern method of contraception. Condoms were the most popular 146 (53.3%) contraceptive method used. Depo-Provera injection was used by 24 (8.8%) of the respondents while 13 (4.7%) used combined hormonal pills.

In bivariate analysis, having at least secondary level of education p< 0.001, mutual agreement with partner p<0.001 and easy access to family planning services p=0.002 were significantly associated with contraceptive use.

In multivariate modeling, mutual agreement with partner and easy accessibility to family planning services was independently associated with contraceptive use (AOR: 3.6; 95%CI [1.82-7.34], AOR: 5.2; 95%CI [0.92-29.32]) respectively.

Lessons Learned: Women who discuss family planning issues with their partners and those who have access to family planning services are more likely to use contraceptive methods. It is essential to integrate family planning service in routine HIV/AIDS care.

P2: 6
Using Integrated RH/HIV Mobile Service Units as a Source of Modern Family Planning Methods in Underserved Areas: The Example of FHI-SA and the DoH MSU project in South Africa
Francis Ogijo Okello, Innocent Ngezni, Hector Rakheti, Tembeka Sonkwele
Family Health International, United States of America; fokello@fhi.org

Background/Significance

Started in 2007 with funding from PEPFAR through USAID-SA, the FHI-SA supported MSU project was set up to provide integrated RH/HIV services to remote and underserved areas in Mpumalanga, KwaZulu-Natal, Eastern Cape and Limpopo provinces. FHI-SA works with the provincial Departments of Health to implement the project. The package of MSU services include: FP, VCT, ART, clinical staging, CD4 count, OI prevention and treatment, TB screening, cervical cancer screening, STI diagnosis, treatment and management, diagnosis of minor ailments and referral. MSU clients represent the most vulnerable groups, dependent on government grants or remittances from employed relatives. The MSU project has contributed greatly to making RH/HIV services available to these populations, supported the government to improve service delivery, resource utilization and health outcomes. However, data are not empirically analyzed to show the results of integrated MSU in delivering RH/HIV services. To address this gap, we use Exhaustive Chi Square Automatic Interaction Detection (CHAID) procedure to specifically measure uptake of modern FP methods among MSUs RH/HIV service clients. Findings will support improvement in project implementation.

Hypothesis or Intervention/Activity Tested

The main purpose is to assess the results of MSU in delivering integrated RH/HIV services, focusing on FP services among RH/HIV clients aged 15-54. The study aims to determine: 1) the extent of use of RH/HIV services by MSU clients, 2) acceptance of family planning methods, and 3) segments with high and low acceptance of modern FP.

Methodology

We use data from client counseling forms completed by MSU nurses during service delivery. A total of 5698 repeat and new clients received various health services from October 2008-March 2009 (including children under 15 and adults 55+). We restrict our analysis to 2522 (82%) male and female clients 15-54 who received RH- or HIV-related services. This age range represents the most likely group to need or use modern FP. Descriptive and inferential analyses are used. Descriptive analysis uses cross-tabulations to examine frequencies of MSU clients, the proportion that voluntarily took or used a modern FP method. The inferential analysis is conducted using the Exhaustive Chi Square Automatic Interaction Detection (CHAID) to construct a three-level depth decision-tree, segmenting clients on the basis of acceptance or refusal to take or use a modern FP method. Exhaustive CHAID investigates interactions between the dependent and predictor variables to show patterns that best explain the dependent variable. Compared to other decision-tree methods, Exhaustive CHAID uses a more extensive search procedure to merge similar pairs of predictors until a single pair remains. The Bonferroni statistic is used to adjust for the significance level when merging and splitting predictors. Findings are validated using split-sample validation with 20% training sample and 80% test sample. The dependent variable is the client’s decision whether or not to accept a modern FP method, and the predictors are: clients’ province, age group, sex, and whether the client is a first time or repeat client.

Findings

RH/HIV services were provided to 82% of all MSU clients aged 15-54. Overall, 60% of RH/HIV clients accepted a modern FP method. Among non-pregnant females, the method of choice was male condoms (67% of repeat and 37% of first time clients). First time females were also more likely to accept an injectable (14%) than the repeat non-pregnant females (5%). Also, 80% of repeat male clients, and 54% first time clients took male condoms. Among all HIV+ clients, 69% of repeat and 53% of first time clients took male condoms.

Adjusted results based on the Exhaustive CHAID show no significant difference between MSU clients from Eastern Cape and Limpopo in terms of acceptance of a modern FP method. Similarly, no significant difference was observed between clients from Kwa Zulu Natal and clients from Mpumalanga. These provinces are automatically clustered accordingly by Exhaustive CHAID based on similarity on the test characteristic. Family planning methods were accepted more by clients from Kwa Zulu Natal/Mpumalanga cluster (78%) compared with the Eastern Cape/Limpopo cluster (39%). In terms of age groups, the 15-24 and 25-34 clients from Kwa Zulu Natal/Mpumalanga had no significant difference in acceptance of a FP method. Likewise, no difference between the 35-44 and 45-54 age groups was identified. Consequently, Exhaustive CHAID procedure merges these groups accordingly. The 15-34 cluster from Kwa Zulu Natal/Mpumalanga had the highest acceptance of a modern FP method (84%), but the 34-54 cluster had equally high acceptance (72%). In the Eastern Cape/Limpopo cluster, age group 15-24, 25-34 and 35-44 are merged automatically based on similarity on the test characteristic. In this cluster, FP uptake was 47% in the 15-44 age range, and 13% in the 45-54 age group.

Knowledge Contribution/Lessons Learned

Results have shown that integrated MSUs can be an important means for delivering FP services to remote and underserved populations. With adequate client counseling, RH/HIV MSU clients demonstrate willingness to voluntarily use FP methods. Differences in acceptance of FP methods by province suggest need for further investigation of local barriers to FP use and development of targeted education interventions to improve knowledge about FP.

P2: 7
Meeting the FP needs of people living with HIV through integration and community based approaches: The Tanzania experience
Rita Badiani, Damian Daniel, Judith Rwakyenda, Diana Shuma, Joseph Banzi, Olivia Sumpter
1. Background:
Tanzania has a population of approximately 34.4 million people, of which 55 percent are under the age of 20. The TFR has not changed since the mid-nineties with women having an average of 5.7 children. While among the least advantaged families, they have eight children or more. The HIV prevalence rate varies by region with an average of 5.8 among the adult population. Partly due to the high fertility rate, pregnancy and birth complications are leading causes of morbidity and mortality for Tanzanian women. By expanding access to reproductive health and family planning activities Tanzania can decrease the rate of maternal and infant mortality, reduce the transmission of HIV/AIDS, and limit the use of unsafe abortion practices. With a CPR of 20% of modern methods among married women, Tanzanian women want to plan and space their children but there is currently a 22% unmet need for family planning services and methods. Furthermore, community home-based care programs have received less attention than other HIV/AIDS programs as potential points of integration. However with the increased availability of ART people living with HIV/AIDS are increasingly feeling health and better and resuming their sexual activity and in need of FP services. This presentation will focus on challenges and lessons learned on the implementation of integration of HIV with MCH.

2. Program:
The RH/FP component has been mainstreamed into the highly successful comprehensive community home-based care (CHBC) program that currently serving people living with HIV/AIDS (PLWHA) and families affected by the pandemic, in multiple regions/districts of Tanzania. The integrated FP activity does not only meet the unique FP needs of people affected by HIV/AIDS, but all members in need of FP services in the target communities. Basic strategies includes equipping outreach workers, including HIV home based care providers, to offer family planning services, including screening, counseling, referral, and provision of condoms and other select methods. These volunteers are linked to HFs for the referrals and supplies of contraceptives.

3. Methodology
Buy in from ward executives on the integrated approach and selection of providers from the HBC program as well new providers from community. Review of CBD curriculum to integrate contraceptive options for people living with HIV, training of community providers and election of a coordinator among the community providers. Training of facility based service providers as supervisors to strengthening linkages with facility, establish two ways referrals and continuous supply of contraceptives. Production of CBPs kit and close support to community providers by the coordinators. Review of in take forms to integrate information on HIV. Adequate monitoring support through monthly meetings between coordinators and community providers as well as supervisors and coordinators.

4. Findings
Community based programs in addition to reaching clients who need services when integrated with HBC it also provide information and training to family members and caregivers who live with the client as well as the neighborhood and therefore have the potential to reach many people. There has been full buy in of the integrated approach by all 92 wards where the project has been implemented so far. More that 90% of the volunteers invited have accepted to add FP in their portfolio and they felt good about it. It helps them to acquire new knowledge and skills and be more active since they now are visiting and reaching a large segment of their community. The project up to this moment has trained 300 community providers and 100 supervisors from the HFs.

5. Program:
The presentation will discuss the following lessons learned:
The support of ward leaders and the community as a whole is important to enhance the use of services and in stimulating the needed changes in the community behavior.
Integration of FP into the HBC program was perceived as very positive by the volunteers. They felt more productive, with new knowledge and skills and good about themselves.
Low paid community providers can be an effective and sustainable strategy to scale up FP services.

P2: 8

An Expedition from Clinics to Community: Understanding Family Planning Program in India

Manas Ranjan Pradhan1, Hiralal Nayak2

1MAMTA Health Institute for Mother and Child, New Delhi, India; 2International Centre for Research on Women, New Delhi, India; manasranjanpradhan@rediffmail.com

Background/Significance:
India has the unique distinction of being the first country in the world to introduce a nationwide family planning program in early fifties. However, in view of the prevalent gender norms that rationalizes the bargaining power of women, lack of informed choice, large-scale sterilization regrets, and high infant as well as child mortality, family planning program in India raise questions that need urgent attention in the broader context of individual freedom and human ethics.

Hypothesis or Intervention/Activity Tested:
The present shape of family planning program is credited to past policies like target approach.

Methodology and Data:
The family planning policy documents along with the Family Welfare Year Books of Government of India has been reviewed and analyzed to illustrate the levels and trends of contraceptive use besides the context of various policies. Additionally, data from the National Family Health Survey-III (2005-06) covering a nationally representative sample of 93089 currently married women aged 15-49 years have been analyzed to understand the determinants of method specific contraceptive use. The data has been analyzed through SPSS 15.0 and the analytical approach includes both bivariate and multivariate analysis. Multivariate analyses have been performed to identify the factors associated with acceptance of specific methods. Geographical Information System (GIS) has been used to show the potential heterogeneity in the data.

Findings:
The initial approach of Indian family planning program was basically clinical with the expectation that people would visit them for the services when in need, the failure of which led the government to switch over to extension approach in the early sixties, thereby taking the program to the people through an extensive network of primary health centers in rural areas and family welfare centers in urban areas. However, with the introduction of method specific targets to reduce the continuing high birth rate in mid sixties, achievement of contraceptive targets rather than client’s services became the major objective of the public service providers. By 1969, the family planning program was fully integrated with the maternal and child health (MCH) program that advocated a
cafeteria approach, but in practice the choice of the methods and the emphasis remained mainly on sterilization. It has been found that contraceptive targets and cash incentives have resulted in the inflation of performance statistics and the neglect of quality services. With the failure of IUD as an acceptable method, once again the program underwent a shift in emphasis towards sterilization camps for carrying out Vasectomy during 1969-74.

The program reached to the extreme during the national emergency (1975-77) with massive sterilizations especially vasectomies carried out in most unorganized and hazardous ways. With the end of emergency and fall of the then government, the family planning program in the beginning of the eighties was renamed as family welfare program embarking a shift in the focus towards Tubectomy. Large-scale post-emergency resistances to Vasectomy besides greater promotion of Tubectomy have been cited as some of the reasons. Mounting national as well as international criticism besides the ICPD program of action (POA) suggesting family planning program to go beyond method specific targets and pay attention to the need of the individuals, especially of women, have led the government to replace 'target oriented approach' with 'target free approach' also known as ‘community need assessment approach’ (CNA) in 1996. Presently, the family welfare program works under the broad umbrella of 'reproductive and child health' (RCH) program since 1997.

Fifty eight percent of the currently married women aged 15-49 are using any modern method of contraception. Despite efforts to promote NSV, prevalence of male sterilization is decreasing (4 percent in 1992-93 to 1 percent in 2005-06). Nevertheless, it appears that female sterilization continues to remain the most emphasized and perhaps the most popular method of family planning in India. Although more than one-third of the Indian women use female sterilization as a method for regulating fertility, people from different socio-economic, religious and demographic strata do not generally opt for sterilization in equal proportion. Sterilization accounts for more than 50 percent of the contraceptive users in the four southern states. Moreover, a sizeable proportion of younger women are not aware of spacing methods. Informed choice has found to be very poor (only about one-third of modern contraceptive users were told about the side effects of their method) and so also the quality of services (fewer than 3 in 10 were told about other methods they could use).

Knowledge Contribution or Lessons Learned:
The need of the hour is to offer choice and quality services. Besides sensitizing the providers about the importance of ethical issues, government need to think over improving information education and communication, better quality services, and importance on spacing methods. Ethics and human values should be of high priority in policy formulation and training of personnel beside public awareness in matters of family planning.

P2: 9

Resilience to Climate Change in Ethiopia: Do Fertility and Reproductive Health Matter?
Aklilu Kidanu, Kimberly Rovin, Karen Hardee
1Miz-Hasab; 2Population Action International, United States of America; KHardee@popact.org

1. Background/Significance
Climate change is already unfolding, and is incurring disproportionate damage on some of the world’s poorest countries. Within these countries, those most economically and socially vulnerable bear the brunt of these impacts, and women are disproportionately represented within these groups. Helping vulnerable populations adapt to climate change is a critical challenge posed to the development community, requiring both sound and equitable strategies, and an in-depth knowledge of what makes people vulnerable to climate change events, and what factors bolster their resilience to impacts, allowing them to absorb impacts and recover without significant declines in quality of life. The need for action is great, but the body of knowledge on which to draw is small, and has largely neglected the needs of women and girls.

2. Research: State Main Question/Hypothesis
The literature on resilience to climate change is relatively new, and there is a gap in understanding of gender and resilience, and more specifically, the importance of reproductive health issues. Our research aims to contribute to filling this gap, asking, "What impacts does gender have on resilience to climate change, and does access to voluntary family planning, and thus smaller family size, contribute to household-level resilience to climate change?"

3. Methodology: Location, Setting, Period, Analysis Approach
This qualitative study in two regions of Ethiopia includes both focus group discussions and in-depth, key-informant interviews with community members, key policymakers, opinion leaders, and civil society organization heads to gain a broader perspective on responses to climate change and climate variability. Participants were recruited from both urban and rural centers. Focus group discussions were held with women and men separately. Respondents also completed a quantitative survey at the beginning of the focus group to collect demographic information and initial opinions on climate change.
The study also included a review of relevant policy documents, including national adaptation plans and poverty reduction strategies.

4. Data
Primary data was collected in the Oromiya and SNNPR regions of Ethiopia, from December 2008 to March 2009. Fieldwork was conducted by the Miz-Hasab Research Center.

5. Findings
This study, while qualitative, contains a wealth of information on men’s and women’s views of climate change, how climate change affects various groups in their communities and how these groups adapt and cope which changes in climate. Preliminary results suggest that people are aware of changes in climate, perceive that the changes have affected and will continue to affect their lives, and recognize that women and children are the groups most vulnerable to climate change as they have the fewest resources to adapt. The findings also suggest that although fertility is highly desired in Ethiopia and people tend to favor larger families, there is a growing awareness that large families are no longer practical or sustainable, and that high fertility exacerbates the effects of changes in climate.

6. Research: State Knowledge Contribution
To date, virtually no studies on resilience and adaptation to climate change have included fertility and reproductive health. This study, therefore, provides an important contribution to our understanding of how people are affected by changes in climate, how they perceive these changes, and whether people consider fertility and access to reproductive health as an adaptation strategy that strengthens their resilience to climate change. The study is also important in highlighting the gender dimensions of resilience and adaptation to climate change.

P2: 10

Covariates of Contraceptive Use: A Cross-Cultural Study of Three Large Indian States
Ravi K. Verma, Ajay K. Singh, Susan M. Lee-Riffe
International Center for Research on Women, United States of America; sleerife@icrw.org
Background/Significance:
Since the family planning programme’s inception in India in 1952, billions of Rupees have been spent to make people aware about different contraceptive methods. Despite the intensity of the national efforts, the program’s achievements have been disappointing. However, knowledge of family planning is universal in India, and the National Family Health Survey (NFHS, 2005-6) demonstrates that 99 percent of currently married women know at least one contraceptive method. Women are most familiar with female sterilization (98%), followed by male sterilization (89 percent), the pill (80 percent), the condom (71%), and IUD (71%). The use of contraceptive method varies by state and region; despite universal knowledge, there are enormous inter-state and inter-district variations in the contraceptive prevalence rate (CPR) and in fertility levels in India.

Tamil Nadu, Maharashtra, and Uttar Pradesh are three states where these variations are quite steep and represent a very contrasting socio-cultural and demographic situation. Maharashtra has a very high contraceptive use (67%) followed by Tamil Nadu (61%), whereas Uttar Pradesh has very low contraceptive use (44%) (NFHS, 2005-06). There is a need to study demographic, social, and political characteristics of these three states, because health and family planning programmes in India are implemented largely at the state level and, Uttar Pradesh, Tamil Nadu, and Maharashtra show contrasting patterns in the use of contraceptive methods.

Hypothesis/Research Questions:
The broad objectives of this paper are to examine the levels and differentials in contraceptive use in these states. We also explore the covariates of contraceptive adoption and as well as unmet needs of family planning of these states which may impact the contraceptive use dynamics of the three different regions.

Data:
Data from three rounds of the National Family Health Survey (NFHS) are used for the study, along with other published documents from the Government of India. The NFHS data are taken for women ages 15 to 49 who were currently married at the survey date. The sample size was 14,210 women in Uttar Pradesh, 8,814 women in Maharashtra, and 5,021 women in Tamil Nadu.

Methodology:
Bivariate analysis and relative percent changes were computed to study change in contraceptive use from NFHS I (1992-93) to NFHS III (2005-06). To examine the factors associated with the use of contraceptive and for adoption of spacing or non-spacing methods, logistic regression models have been used.

Findings:
There has been significant relative change (35%) from 1992-93 to 1998-99 in Uttar Pradesh, and this change is even more pronounced between 1992-93 and 2005-6 (55%); the corresponding figures for Tamil Nadu and Maharashtra are 18 percent and 23 percent respectively. The analysis also indicates that among contraceptive users, a large number of currently married women have accepted a terminal method (female sterilization) in Maharashtra (81%) and Tamil Nadu (91%). In Uttar Pradesh, relatively higher proportion of women reported using spacing method (27%); only about 41 percent reported using a terminal method. Thirty-two percent of women from Uttar Pradesh also reported using traditional methods (i.e., withdrawal, periodic abstinence, etc.) Among all the background characteristics, increases in women’s education, her husband’s education, and wealth index are associated with increasing acceptance of spacing methods. The analysis also demonstrates clear evidence of son preference. Couples are less likely to use contraception or use a spacing method if they have no sons or if they have more daughters than sons.

About 13 percent of women in Tamil Nadu and Maharashtra and over 25 percent of women in Uttar Pradesh have unmet need for family planning. The unmet need in all these states are almost equally divided between unmet need for spacing births and for limiting births.

Knowledge Contribution:
On the basis of foregoing analysis carried out for the three large states of India which comprises nearly one-third population of the country, the contraceptive dynamics and fertility regulation behavior would largely determine the fertility trends and health conditions for the country as a whole. The NFHS data from 2005-06 demonstrate an estimated TFR of 3.8 in Uttar Pradesh and a contraceptive prevalence rate of 33 percent; in Tamil Nadu and Maharashtra, the estimated TFR was 2.1 and 2.6 respectively, quite close to replacement level in Tamil Nadu and not far away in Maharashtra. In the transition model, Uttar Pradesh with a relatively high TFR, low contraceptive use, and average breastfeeding duration of 25 months, would have reached Stage III. At the other end, Tamil Nadu and Maharashtra, with a relatively low TFR, high contraceptive use, and average breastfeeding duration of 17-24 months, may already have reached Stage IV. In the contrasting patterns, as observed, it appears that the contraceptive acceptance and fertility regulation behavior would make an important dent in the population of these states, largely on Uttar Pradesh.

P2: 11
Does use of contraceptive effect overweight/obesity among Indian women?
PraWEEN kunar Agrawal1, Sutapa agrawal2
1India HIV/AIDS Alliance, India; 2South Asian Centre for Chronic Disease Research; praween_agrawal@yahoo.com

Does use of contraceptive affect overweight/obesity among Indian women?

(1) Background/Significance:
Women’s health issues have come into consideration specifically in the last decade of the last century. Contraceptive health is one of the important aspects. People making decisions concerning contraceptive research priorities should take into account women’s health needs as women define them and principal factors, which affect women’s ability to use contraceptives safely and effectively. Lack of adequate knowledge and information about side effects of contraceptives have made women vulnerable to suffer from severe health problems that are beyond their control. Perceived weight gain is a common complaint among women who use oral contraceptives. Also IUD and sterilization are blamed for weight gain in the perception of women. But how much these contraceptive methods are responsible for actual weight gain is a matter of research. Although weight gain is often cited as the reason for non-use or discontinued use of oral contraceptives, studies fail to associate use of oral contraceptives with significant weight gain. Available literature shows inconsistent results regarding the effects of oral contraceptives on body weight gain; some cohort studies reported significant effects while some clinical studies reported non-significant effects.

Though in India researches have related obesity with disease outcomes like diabetes, hypertension, and heart disease and asthma but there are lack of studies in a representative population linking the effect of contraceptive use on subsequent obesity. The large-scale survey in India collected anthropometric data from a nationally representative sample as well as data on fertility and family planning use in India, which provide an opportunity to see the effects of contraceptive use on subsequent obesity. On the above context, the major objective of the study is to examine the effect of contraceptive use on obesity among women in
India. However, specific objective of the paper is to see the effects of duration of use of sterilization, pill and IUD on subsequent overweight/obesity among women.

(2) Hypothesis:
- There is positive association between contraceptive use and BMI status among married women in India.
- Higher the duration of use of sterilization, pill and IUD among women higher is the overweight/obesity among them.

(3) Methodology:
First, simple bi-variate analysis has been done and results are presented in percentage. Further, logistic regression method was used to estimate the effects of contraceptive use on BMI after controlling for other demographic and socioeconomic variables because the response variable i.e. BMI is found dichotomous (normal and overweight/obese). Results are presented in the form of odds ratios (OR) with 95% confidence intervals. The logistic regression models were estimated using SPSS package. In the survey, certain states and certain categories of households were over sampled. In all analysis in this study, weights are used to restore the representativeness of the sample (IIPS and ORC Macro, 2000).

(4) Data:
Data is from India’s second National Family Health 99. This survey was designed on the lines–Survey (NFHS-2) conducted during 1998 of the Demographic and Health Surveys (DHS) that have been conducted in many developing countries since the 1980s. NFHS-2 collected demographic, socioeconomic, and health information from a nationally representative probability sample (except the small Union Territories) of 90,303 ever-married 49 years residing in 92,486 households. All states of India are–women aged 15 represented in the sample, covering more than 99 percent of country’s population with an overall response rate of 98 percent. Details of sample design, including sampling frame and sample implementation, are provided in the national report for all India (IIPS and ORC Macro, 2000). The analysis here is based on 49 years living in the sample–non-pregnant 75,554 ever married women aged 15 households who has not given birth in the two months preceding the survey.

(5) Findings:
The result shows that modern contraceptive methods such as sterilization and IUD do not influence weight gain in married women. Effect 30.0:of contraceptive use on overweight (BMI 25.0-30.0 kg/m2) and obesity (BMI kg/m2) was only marginal when women’s socio-economic and demographic characteristics were controlled. However, prolonged duration of pill use was found to be positively associated with obesity among women.

(6) Knowledge Contribution or Lessons Learned:
Finding of this paper corroborate that, role of sterilization, pill and IUD are not much significant for overweight and obesity among women in India. On the other hand the other factors like residence, occupation, standard of living and food habits have relatively more prominent effects on overweight and obesity among women. Therefore, contraceptive use should not be blamed as reason for weight gain.

The result is useful for policy point of view and the health care providers should counsel potential users of pills and IUD to increase the acceptance and promote the use of temporary methods of family planning, which is quite low in India.

Key words: Overweight, obesity, sterilization, pill, IUD, India.

P2: 12

Multi varied cross sectional analysis of some key determinants of total fertility rate in sub Saharan Africa: Evidence for effective FP programming in Nigeria

Onoride Estire, Jennifer Anyanti, Samson Adebayo, Banji Oladipo
Society for Family Health, Nigeria; Oezire@sfhnigeria.org

Background:
Total fertility rate (TFR) which is the average number of children born to each woman over the course of her life is an important indicator of the population trend of a country. In general, the total fertility rate is a better indicator of (current) fertility rates because unlike the crude birth rate it is not affected by the age distribution of the population.

Fertility rates tend to be higher in less economically developed countries and lower in more economically developed countries. What are some of the key social and economic factors that account for this? Amidst dwindling resources, it’s important that factors that tend that exert greater influence on population are identified for effective and efficient intervention.

Hypothesis:
Ho: rxy = 0 (The linear association equal zero)
Ha: rxy ≠ 0 (There is a linear association between the dependent and independent variables)

Where x is the dependent variable and y the different independent variables

Level of significance: 0.05

Method
In exploring this, data were collected from 16 Sub Saharan African countries. While it is recognized that there are national variations, all the countries base on World Bank’s classification are low income countries. They are also regarded by UNFPA ratings as priority “A” countries in terms of needs for population intervention. Amidst limited data availability, the following 6 exogenous variables: illiteracy level of women aged 15+, Age at first marriage of females, rate of use of modern contraceptives, women aged 15 – 49 who are resident in urban centers, total unmet FP needs and the per capital income (PPP for comparison) were statistically run against the endogenous variable Total Fertility rate. Considering that the data are aggregated, the Pearson correlation coefficient was used for the analysis.

A functional relationship started below was proposed

TFR = f(Ed, Afm, Cu, Lo, UMFp, PCY)

Such that: TFR = Total fertility rate, Ed = Literacy level, Afm = Age at first marriage, Cu = Rate of contraceptive use; Lo = Location (Urban or Rural); UMFp = Total Unmet FP needs; PCY = Per capital income
Data:
Countries TFR % of Illiteracy rate among females age 15 + Mean age of first marriage Rate of contraceptive use among females age 15-49 % of urban based pop
Total unmet FP needs in % Per capita income in PPP
Benin 6.1 76 18.3 3.4 43.8 25.7 990
Burkina Faso 6.89 86 19.4 8 17.2 25.8 976
Cape Verde 3.56 34 25.7 46 64.5 na 4863
Cote d’ Ivoire 5.1 63 19.8 7.3 44.5 27.7 1630
Gambia 5.2 70 9 31.9 na 1649
Ghana 4.6 37 21.1 13.3 36.8 23 1964
Guinea 6.27 na na 4.2 28.5 24.2 1982
Guinea Bissau 5.99 77 18.3 3.6 33.1 na 755
Liberia 6.8 63 19.7 5.5 46.1 na na
Mali 7 84 18.9 5.7 31.6 25.7 797
Mauritania 6 70 23.1 5.1 60.3 31.6 1677
Niger 8 92 16.6 4.3 21.6 16.6 746
Nigeria 5.9 24 18.7 8.6 45.8 17.4 896
Senegal 5.57 72 20.1 8.1 48.8 34.8 1510
Sierra Leone 6.5 na 18.3 38 490
Togo 5.8 57 20.3 7 34.5 32.3 1442
Compiled from the UNFPA Population and Reproductive Health: Policy Developments and Indicators 2003

Findings:
Illiteracy rate Mean age of first marriage Use of modern contraceptives Urban population Total unmet FP needs Per capita income
Correlation Coefficient .754 -.753 -.732 -.610 -.293 -.767
p. Value .001 .001 .001 .012 .271 .001
• With a significance level of .05, in statistical terms, we reject the null hypothesis there is no linear relationship between TFR and the independent variables Ed, Afm, Cu, Lo, PCY as the p-value of the correlation coefficient is < than 0.05:
• We however accept the null hypothesis that there is no linear relationship between Total fertility rate and total unmet FP needs as the p value of the correlation coefficient is greater than the significance level (.271 > 0.05)

Knowledge contribution (Policy and programmatic implication for FP services in Nigeria):
• Investment in the girl child in the form of education and economic empowerment are good and effective strategy for population intervention in Nigeria.
• Urban population has more access to information and possibly commodities and sexual and reproductive health services. Knowing that more than half of the Nigeria population resides in rural areas, deliberate efforts should be made to improve their lives
• With a modern contraceptive use rate still lower that 15%, efforts should made to increase demand and access to modern FP methods as it has a strong correlation with total fertility rate

P2: 13
Integration of family planning (FP) into PMTCT services in Kenya
Jennifer Katunge Liku, R. Masaba, M. Solomon, M. Kuyoh, E. Jackson
Family Health International, Kenya; jliku@fhi.org

1. Background/Significance
Prevention of Mother to Child Transmission (PMTCT) as part of HIV programs are being implemented in several countries in Africa including Kenya. Mother to child transmission of HIV (MTC) can occur during pregnancy, labor, delivery and breastfeeding. To optimize the effectiveness of PMTCT, World Health Organization promotes a four-pronged comprehensive approach aimed at preventing MTC. Family planning services within PMTCT need to be strengthened so that all women (HIV infected and uninfected) can make informed decisions about their future reproductive life including when to seek appropriate support and services to prevent unintended pregnancies. Most HIV-infected women in developing countries do not know their serostatus and increased availability of counseling and testing services at antenatal and child welfare clinics and maternity wards (labor and postnatal) would enable them to obtain essential care and support services including FP.

In spite of the rapid scale up of Kenya’s national PMTCT program in antenatal and maternal child health clinics where FP is an integral part of services use of effective contraception remains an unexploited intervention among patients in child welfare and post natal clinics. An assessment of FP services in PMTCT settings revealed high levels of unmet need for FP and inadequate screening for unintended pregnancy among clients.

2. Program: Intervention/activity tested
In collaboration with the Ministry of Health, FHI will strengthen FP in maternity wards, antenatal and child welfare clinics to increase the opportunity for women to access family planning services. Activities involve strengthening a FP module within the revised PMTCT curriculum; assessment of data capture tools and collection of baseline service statistics in the various service delivery points in selected sites in Coast and Rift Valley provinces to determine provision of FP services; support for the MOH to field test, revise and print PMTCT training materials that will be rolled out afterwards for universal use; training of service providers on integration of FP into PMTCT services to minimize missed opportunities for provision of FP services; orientation of program managers and facility
in-charge to ensure support and supervision of integrated services; and collection of service statistics to determine and monitor uptake of FP services in PMTCT settings.

**Methodology (including location, setting, period, analysis approach)**

The intervention will be undertaken in Coast and Rift Valley provinces of Kenya as described above. Baseline and end line data will be compared.

**Findings**

Baseline data expected in Sept 09

5. Program: Lessons learned

Earlier efforts to integrate FP counseling and referral in maternal and child health (MCH) services have shown that more women (HIV infected and uninfected) have greater access to family planning services. Further, training of providers is necessary to refine family planning knowledge and skills, and minimize the likelihood of bias in service provision. In addition, managers of health facilities have a role to play in getting their staff to appreciate strengthening of FP in all MCH services to reach all women attending these services with information and/or services on family planning hence the need to orient them on FP-PMTCT integrated services.

**P2: 14**

**Éléments de relance de la planification familiale au Togo dans un processus d’évolution lente de la prévalence**

Koffi Koumagnanou

Population Services Internationales/Togo (PSI/Togo), Togo; koffilis@yahoo.fr

1. Contexte/Importance ;

Au cours de ces dernières années, plusieurs études montrent une baisse de la fécondité en Afrique subsaharienne. Plusieurs raisons expliquent cette baisse selon les contextes. Il s’agit de l’âge au premier mariage, la forme de l’union et les conditions de vie des ménages. Aussi la contraception joue-t-elle un rôle important sur cette réduction. Les programmes de santé de reproduction et de la planification familiale ont connu une expansion. De vastes projets ont été mis en œuvre comme le projet Santé familiale et prévention du SIDA exécuté au Cameroun, en Côte d’Ivoire, au Burkina Faso et au Togo. Cependant la prévalence contraceptive en Afrique subsaharienne est faible et les besoins non satisfaits en planification familiale sont généralement au dessus de cette prévalence. Au Togo, la prévalence contraceptive est 17% dont 11% pour les méthodes modernes alors que les besoins non satisfaits est 41%. Ainsi on se pose la question sur les déterminants de la pratique contraceptive au Togo.

2. Recherche : Indiquer la question/hypothèse principale ;

Plusieurs recherche ont abordé la question et ont identifié les déterminants socio démographiques. Toutefois les déterminants psychosociaux sur lesquels les politiques peuvent agir sont rarement ou presque pas explorés particulièrement au Togo. Ainsi cette étude se pose une question : quelles sont les variables psychosociales qui sous-tendent l’utilisation des méthodes contraceptives modernes au Togo ? L’hypothèse faite est que la faiblesse de la prévalence est liée à une mauvaise opinion individuelle directement modifiable par les programmes de planification familiale.

3. Méthodologie (y compris le lieu, la situation, la période, l’approche adoptée pour l’analyse);

L’approche utilisée dans est essentiellement qualitative des groupes de discussion ont été organisé afin de décrire et de comprendre les perceptions, les interprétations et les croyances des femmes de 15 49 ans en matières de planification familiale au sud du Togo. La constitution des groupes est basée sur l’âge, le sexe, le milieu de résidence, la situation matrimoniale et l’utiliser ou non d’une méthode contraceptive moderne. Chaque discussion est enregistrée et transcrite. Les données sont ensuite codifiées puis compilés suivant les déterminants identifiés. Un résumé spécifique à chaque déterminant est produit. Il s’agit d’une analyse de contenu. De plus des sources secondaires sont utilisées pour comprendre l’évolution de la contraception au Togo.

4. Données (s’il y a lieu) ;

Au Togo il n’existe pas d’étude sur les déterminants psychosociaux de la pratique de méthodes contraceptives modernes. Ainsi cette étude sert de base pour l’identification des déterminants et constitue une étape antérieure aux recherches quantitatives. Les données servant à cette analyse sont issues des groupes de discussion. Elles s’intéressent globalement aux fondements socioculturels de l’utilisation des méthodes contraceptives modernes ou de la planification familiale. Au total 32 groupes de discussion sont réalisés avec environ 186 personnes. Ces données sont complétées par les informations des rapports des EDS et des MICS.

5. Conclusions ;

La planification familiale au Togo connaît une évolution positive avec une augmentation sensible de la prévalence contraceptive. Ce qui est en partie les résultats des programmes dans le domaine. Néanmoins un travail énorme reste à faire. Il pourrait porter sur les déterminants psychosociaux qui peuvent être directement modifié par les programmes de santé. Au Togo il s’agit des normes sociales liée à l’utilisation des méthodes contraceptives modernes et de la valeur sociale de l’enfant, des pressions perçues de la part de la société, du soutien social, de l’attitude, de la qualité de service, des croyances et des points interne ou externe de contrôle. Ceci en capitalisant sur la perception de la sévérité du manque de planification, les résultats attendus par rapport aux méthodes et de la disponibilité des produits et/ou des méthodes. Cependant vue la pluralité des facteurs une question demeurent : quel hiérarchisation faut-il dans la planification des actions pour mieux prendre en compte ces facteurs ?

6. Recherche : Indiquer la contribution aux connaissances ;

Programme : Indiquer les leçons tirées.

Les programmes de planification familiale ont gagné de terrain au Togo. Cependant ils contiennent en leur sein un système de freinage pour une évolution rapide de l’adoption des méthodes modernes. En effet, les effets secondaires liés à l’utilisation des ces méthodes constitue un facteur de blocage. Il faudrait intégrer dans ces programmes des aspects d’information et si possible de prise en charge de ces effets.

**P2: 15**

**Does availability of HIV-related health services affect fertility preferences and contraceptive use in four Sub-Saharan African countries?**

Akirinola Bankole,1 Ann E. Biddlecom2, Isaac F. Adewole2

1Guttmacher Institute, United States of America; 2University of Ibadan, Nigeria; abankole@guttmacher.org

Background/Significance: Two recent trends in HIV-related health services in Sub-Saharan Africa introduce new questions about what this may mean for women’s and men’s fertility preferences and contraceptive behavior. The first trend is the expansion in anti-retroviral treatment for people living with HIV; in
particular, drug treatment for HIV-positive pregnant women to lower the risk of HIV transmission to newborns, and anti-retroviral therapy for HIV-positive people in general, to improve quality of health by reducing the symptoms of the disease, and to lengthen their life expectancy. For example, HIV treatment has risen dramatically in Zambia from just 10,000 people on ARVs in 2004, to about 120,000 by mid 2007. The second trend is the increasing availability of HIV testing in the region, and in particular availability of new rapid HIV tests, combined with increased support for and implementation of opt-out testing in some countries. The expectation of governments and providers is that if more individuals are aware of their HIV status, use of contraception, including the condom, to prevent partner infection and to limit fertility as well, may become more widespread. On the other hand, increased availability of ART may boost people’s motivation to have children as the drugs enhance the health and survival of people living with HIV and prevent mother to child transmission of the infection. Little is currently known about how individuals will react to these HIV-related service trends. There is, therefore, a need for research to tease out these program and policy relevant relationships.

Hypothesis: We expect that women and men living in areas where a higher percentage of facilities have ART, HIV testing and counseling and PMTCT services will be less likely to want to delay or stop childbearing and to use contraception. We also posit that greater availability of HIV related services will close the gap between the fertility preferences and contraceptive use of HIV positive men and women compared to their HIV negative counterparts.

Methodology: We examine three outcomes: 1) Want more children; 2) unmet need for contraception (any method); and 3) used condom at last sex. The key independent variables measure the percentage of health facilities in a geographic area (e.g. province or region) that offer a) voluntary counseling and testing (VCT); b) clinical care and support services for HIV/AIDS patients and people living with AIDS (CSS); c) anti-retroviral therapy (ART); and d) prevention of mother to child transmission (PMTCT). To test the first hypothesis, we will relate these variables to individuals’ fertility preferences and contraceptive use, net of the effects of personal factors. For example, we will be able to say whether and in what direction availability of ART or PMTCT is associated with women and men’s fertility preferences and contraceptive use. We also construct a composite variable of HIV status (from biomarker data) and likely knowledge of status (from self-report of ever having an HIV test & receiving the results) that has four categories: HIV+, likely know; HIV+, don’t know; HIV-, don’t know; and HIV-, likely know. We examine associations between this measure of HIV status and fertility preference and contraceptive use controlling for the effects of personal characteristic variables. To test the second hypothesis, we will determine whether or not any observed association changes when the HIV related services variables are included in the analysis. Logistic regression models control for age, urban/rural residence, education, household wealth quintile, number of living children and union status will be employed.

Data: We draw on individual data (self-reported information and HIV biomarker) from the most recent Demographic and Health Surveys (DHS) in Kenya, Rwanda, Zambia and Tanzania. These data are merged with facility-level information on HIV-related services from the Service Provision Assessment (SPA) conducted in each country (Kenya (2004), Rwanda (2007), Tanzania (2006) and Zambia (2005)). In 2004 MEASURE DHS developed a special HIV/AIDS SPA to meet the needs of the President’s Emergency Plan for AIDS Relief. These data are now available for a number of countries in Sub-Saharan Africa.

Findings: Preliminary findings indicate that the fertility preferences of HIV positive women and men are generally similar to those of their counterparts who are HIV negative, and where there is a difference, the former are more likely to desire to stop childbearing than the latter. On the other hand, people who are HIV positive and likely know it are generally more likely to use condoms at last sex than those who are HIV+ and don’t know it or are HIV negative.

Knowledge Contribution: The proposed analysis will contribute to knowledge about how availability of HIV related services might affect people’s preferences and behavior with respect to fertility and contraceptive use. It will move discussion around these issues beyond mere speculations and provide helpful information to program planners and policy makers to help individuals, irrespective of their HIV statuses, achieve their fertility and contraceptive goals.

P2: 16
Assessing Contraceptive Knowledge Attitude and Practice among Women of Reproductive Age in Kabusa Community Abuja

Chukwudera Bridget Okeke, Michael Olasimbo Kofoworola

Center for Right to Health, Nigeria; talkwitody@yahoo.com

Background/Significance:
1. The practice of family planning depends on knowledge, attitude, access and availability of methods of choice use. Studies have shown that family planning serves as the best way for birth spacing and reduce child mortality. It was also shown that the health risks associated with contraception are low relative to the risks of a typical pregnancy and especially to the risks of an unintended pregnancy.
2. Research: State main question/hypothesis
Program: State intervention/activity tested
Hypothesis:
1. Women Level of Education have influence on the use of contraceptives
2. Religious factor may likely affect attitude of women towards contraceptives
3. Women level of awareness may influence their knowledge on contraceptive

Methodology (including location, setting, period, analysis approach) Methodology:

3. Data (if relevant)
Findings: Findings:
A total of 200 women of reproductive aged were studied. More than half of the women (92%) agreed with the statement that family planning (FP) methods are effective. (80%) of the women lack in depth knowledge of modern contraceptive usage. A higher proportion of sexually active unmarried women, knew at least one modern contraceptive method (90%) compared to women with no sexual experience (20%) and women in union (76%). Among the modern methods, the most known by women of reproductive age is condom (70%), Injectable (10%) and oral contraceptive pill (5%). Less than a quarter of the respondents (10%) knew of emergency contraceptive (EC). Among sexually active unmarried people, only (10%) knew of emergency contraceptives. (72%) of the women reported rhythm as the most natural method. (94%) of these women has low knowledge of how to use female condom and its availability.

6. Research: State knowledge contribution
Knowledge Contribution:

- Women that are educated have more knowledge of the use of contraceptive
- Cultural practice and belief is a high factor that affect the use of contraceptive among women of reproductive age in Kabusu community
- Patriarchy affect the use of contraceptives among women of reproductive age in Kabusu Community.

Program: State lessons learned

Lesson Learnt:

- Educating couples about the range of methods and their possible health risks and subsidising the cost of contraceptives
- Organizing a effective family planning programme, this will promote wider knowledge about the range of contraceptive methods and its use.
- Health agencies in Nigeria should make contraceptive available and in cheaper price
- Appropriate counseling and involvement of male partners in decision making to reduce discontinuation of contraceptives.
- Improve methods of reaching client population especially young women.

P2: 17

The Power of Misinformation on Contraceptive Decision Making: Ghanaian Example

Sirina Reddy Keesara, Martha Campbell
Venture Strategies for Health and Development, United States of America; sirina.keesara@gmail.com

1. Background/Significance: Misinformation about family planning has been widely overlooked as possible factor explaining low contraceptive use in many low resource countries. Many researchers have attributed the difference between the number of women aware of contraception and the number using it to cultural resistance as well as a preference for high fertility. In addition, studies have shown that rumors and anxiety about contraceptives are among the reasons women decide against the use of contraception. In the Ghana 2003 DHS, fear of side effects was cited as the most common reason that women were not using modern contraception (37.3%). These are all intangible barriers to family planning use, which are often hard to quantify, and need to be added to considerations of “costs” of contraceptive use.

2. Research: State main question/hypothesis: To what extent does misinformation create a barrier to family planning use? In addition, might it be possible that misinformation affects reported family size goals?

3. Methodology (including location, setting, period, analysis approach): A qualitative study was undertaken in Ghana in order to gain understanding about the relationship between misinformation and contraceptive use. Using a convenience sample, 110 semi-structured interviews of women were conducted in two locations in Ghana: Accra (capital city in southern Ghana), and in Nakpanduri (a small rural town in northern Ghana). Interviews were modified throughout the course of the study to explore topics that emerged. They were transcribed and coded, and themes were identified.

4. Data: Not relevant because this is a qualitative study.

5. Findings: As reflected in the Ghana 2003 DHS, our interviews indicated that fear of side effects was the most common and consistent response for not using contraception. The “side effect” that women feared the most was that contraceptive use would endanger their ability to bear children in the future. In addition, some mentioned fear of actual side effects such as weight-gain, nausea and fatigue. They also gave a variety of answers often found in the DHSs: their opposition to using contraception due to various reasons such as husband preference, religion, fear of maltreatment in the clinics, lack of privacy and other concerns.

A startling contradiction arose in a consistent pattern throughout the course of the interviews. When women were asked “would you use contraceptives if they did not negatively affect long-term fertility?” nearly all of them agreed enthusiastically that they would, despite earlier opposition. Essentially these women were discarding all of their earlier reasons for not using contraception once they heard of the possibility that it wouldn’t affect their future fertility.

The implications of this seem important, as one of the reasons for their not having used contraception seems to have trumped all of the other reasons. These interviews showed that the ability to have children later in life is important to these women, and contraception does not affect this ability, then they considered it an attractive option.

This implies that with correct information, women in Ghana might potentially have a contraceptive prevalence rate substantially higher than the current one.

In addition, a few of the women indicated a lower desired family size when they were offered this concept of contraception’s not inhibiting their future fertility. Other factors, such as child mortality, husbands’ preferences, economic considerations and religious doctrines, affected women’s stated fertility preferences.

Secondary observations in this study concerned the differences between Accra and Nakpanduri with respect to their beliefs and actions around contraceptive use, which appears to be affected by their differences in availability of contraceptives and information, and the degree of anonymity in their respective settings.

6. Research: State knowledge contribution: This fieldwork indicates that beyond general misinformation as a significant intangible barrier to contraceptive use for these Ghanaian women, one special kind of misinformation that contraceptive use inhibits future fertility appears to be a stronger influence than the rest. It seems that with correct information, women can have greater freedom to make informed decisions about their fertility. In addition, the concept of “costs” of contraception needs to be broadened to include intangible barriers. Understanding these intangible barriers to contraceptive use could have important implications for reducing unintended pregnancies, and possibly also for reducing family size.

P2: 18

HIV/RH integration in hard to reach populations, case of female Commercial Sex workers in Uganda

Sarah Mbabazi, Muna Shalita
Program for Accessible Health, Communication and Education, Uganda; pace@pace.org.ug

Background:

The Uganda HIV/AIDS Sero-Behavioral Survey 2004/05 showed that the HIV prevalence is very high (8.3%) in northern Uganda compared to the national level of 6.4%. In addition, northern Uganda as a whole and the internally displaced populations (IDPs) have the highest rate of teenage pregnancy and lower levels of contraceptive use, knowledge on HIV/AIDS and condom use during higher risk sex than national averages. Extreme poverty, unemployment, and gender inequality make some young women engage in commercial and transactional sexual relationships with salaried men as a major means of survival. This is the direct result of the 20 year protracted war that left districts inaccessible and underserved at all levels of health care system.
Program:
In July 2008, the Program for Accessible Health, Communication and Education (PACE) launched a reproductive health in Emergency project in Uganda in the northern districts of Kitgum and Pader. Funded by UNFPA, the interventions seek to provide integrated HIV/reproductive health services to most at risk populations including female commercial sex workers (FCSWs). Through peer education, provision of mobile HIV Counseling and Testing (HCT) services, referral for care and support including sexually Transmitted infections (STIs) management, provision of contraceptives and condoms; this high risk group is reached with knowledge and tools that facilitate them to address their most pressing reproductive health needs.

Methodology:
In order to have effective interventions among FCSWs, a rapid assessment was conducted among FCSWs in the two districts. This assessment helped in developing strategies to be used to effectively target and engage FCSWs in HIV/reproductive health intervention which included: targeted mobile HIV counseling and testing outreach at “hot spots” as an entry to provide other reproductive health services like family planning and STIs treatment, use of “pimps” to mobilize FCSWs, training of FCSWs as behavior change agents among fellow FCSWs, empowering FCSWs with condom use and negotiation skills, distribution of condoms and contraceptives during outreaches as well as referral for care and support services of those infected with HIV.

Findings:
Consequently, over 1,500 FCSWs have received HIV Counseling and Testing services, 200 received STI treatment, 600 got family planning services and about 150 were referred for care and support services. In addition over 50,000 condoms were distributed to CSWs in the two districts in 9 months. As a way of entrenching interpersonal communication, training of 150 peer educators among FCSWs was also carried out to facilitate behavior change among fellow FCSWs.

Lessons learned:
Use of peer FCSWs to mobilize their fellow FCSWs for services helped a lot in increasing demand and uptake of services by FCSWs.

Involving lodge, bar and Night club owners as “pimps” in mobilization/sensitization for activities among FCSWs enabled smooth implementation of activities among this high risk group.

Targeting peak periods like the beginning and end of every month, big occasions and disco days when FCSWs trek to specific locations in big numbers following their customers was very key in ensuring increased uptake of services by FCSWs.

For successful implementation of activities among FCSWs, maintenance of maximum confidentiality is very important as there is a lot of stigma from the community towards commercial sex workers in the two districts.

Empowering FCSWs with condom negotiation skills was very vital in trying to reduce risks of HIV transmission as most FCSWs lacked condom negotiation skills.

Some FCSWs fall prey of sexual gender based violence by their customers, therefore integration of sexual gender based violence activities is necessary while implementing HIV/reproductive health activities among FCSWs.

The mobile nature of FCSWs makes repeat testing for HIV and follow on support services like on going supportive counseling a bit difficult.

In order to have a better impact on ground, interventions that target FCSWs should also be extended to the uniformed services as there is a lot of interaction between the two groups of people.

P2: 19
Assessing the Reproductive Health Training Needs of Religious Leaders: A Pilot Study
Oinama El-Gibaly
Assiut University, Egypt; oelgibaly@yahoo.com

1. Background/Significance: Mobilizing religious leaders to take an active role in reproductive health and family planning is currently documented to be one of the successful best practices. Muslim religious leaders have a strong impact on their societies and success of various RH programs. The power they exert on individuals and programs reflects itself in the success story of the family planning program in Egypt due to their approval of contraceptive behavior; while their disapproval of the use of sterilization as a FP method resulted in reluctance in its acceptance by women and health care providers What health planners know about religious leaders working conditions, involvement in community activities, their knowledge of the MDGs, their knowledge and attitudes in /Reproductive health and reproductive rights, whether they rely on internet sources for information, perception of community needs, priority areas of intervention, as well as their perception of the impact of the previous training in which they have been exposed is markedly lacking. This paper explores these dimensions among two groups religious leaders; one that has been exposed to training on RH issues and the other was not exposed to training on RH in Assiut city.

2. Research: State main question/hypothesis:
   a. What are the reproductive health training needs of religious leaders in Assiut, Egypt?
   b. Are trained leaders different in their socio-demographic, personal characteristics, and activities in their communities compared to untrained religious leaders?

Program: State intervention/activity tested, none

3. Methodology (including location, setting, period, analysis approach): Two groups of trained and untrained religious leaders in Assiut city were identified from the directorate of Awkaf [local administration for religious leaders] for comparison. A semi-structured self-administered questionnaire was prepared and tested prior to data collection. Data on personal, socio-demographic, activities in their communities, daily tasks, knowledge and attitudes on RH, reproductive rights, gender, HIV/AIDS, FGM, domestic violence, were included.

4. Findings: The wide distribution of religious leaders in all rural and urban communities is advantageous and call for co-ordinating their activities with the rural and urban PHC teams. Empowering religious leaders with RH knowledge, skills of communication, as well as defining a specific role can boost all RH programs.

5. Research: State knowledge contribution

Program: State lessons learned

P2: 20
The effect of women empowerment on modern contraceptive use in Uganda
Simon Sebina Kibir, B. Kwagala, E. Sekatawa
Background: The proportion of women using modern contraceptives in Uganda is still very low (18%). There is need to establish measures to increase contraceptive uptake in order to reduce on the high levels of fertility and unplanned births. We established the association between women empowerment and use of modern contraception in marriage in Uganda.

Methods: We analysed the 2006 UDHS data. The study population included 5337 married women at the time of the survey aged15-49 years. We developed three women empowerment indices from a number of variables; power over earnings, household decision making and attitudes towards issues of gender equity and rights. These indices were categorised into low, medium and high power levels. The effect of women empowerment on use of modern contraception was established using logistic regression.

Results: All the three women empowerment indices independently had strong positive influence on modern contraceptive use. Women with high or medium levels of empowerment were more likely to use modern contraception compared to those with low levels. Power over earnings (OR=1.53 for high and 1.82 for medium), decision making (OR=1.23 for high and 1.19 for medium) and for gender equity (OR= 2.35 for high and 1.49 for medium). Reference category for all indices was low.

Conclusion: Women empowerment affects uptake of modern contraception among married women in Uganda. There is need for more efforts in areas that relate to empowerment of women and their rights so as to contribute to increased use of modern contraceptives.

P2: 21

Integrated Services: How do we measure and evaluate?

Saumya RamaRao1, Estela Rivero-Fuentes2, Charlotte Warren, Saiqa Mullick, Harriet Birungi, Ian Askew, John Townsend3

1Population Council, United States of America; 2El Colegio de Mexico, Mexico; sramaro@popcouncil.org

Background

The vertical family planning programs of the 1970s are a far cry from current sexual and reproductive health programs. Sweeping changes have occurred in many realms: from a paradigm shift in global thinking that individuals need comprehensive reproductive health services, reform of the health sector in many countries, to emergence of HIV and AIDS as new public health challenges. One consequence of these changes has been the move towards integrated services. Integrated services are increasingly being seen as a promising way to address individuals’ multiple needs over time and across different levels of the health system (WHO, 2008).

Integration of family planning services with other key sexual and reproductive health services has received international endorsement over the past two decades with a growing body of knowledge and models of service delivery. The earliest models of integrated services focused on integrating family planning into existing MCH services as in Africa. More recently, newer integrated models have emerged that integrate family planning information and services into specific components of MCH services such as antenatal, delivery, and postnatal care. For example, provision of family planning counseling and information to pregnant women visiting antenatal clinics; provision of family planning information and services to newly delivered women and postabortal women; and development of integrated postnatal and family planning package of services for the mother and the newborn (Rivero-Fuentes et al., 2008). In addition, there are growing numbers of models that provide family planning information and services integrated with services for the prevention, management and treatment of HIV/AIDS.

Many rationales have been espoused for integrating family planning into other services including that it is a feasible strategy for improving access and availability of services to potential clients, serve multiple client needs at the same time, reduce stigma for some services such as HIV and safe abortion, and potentially allow programs to achieve cost and other efficiencies. Despite the many models of integrated services, many questions remain. Illustrative questions are: (1) whether integrated services are feasible, and if so, which service combinations are feasible; (2) whether integrated services are acceptable to providers and clients; (3) whether improving access by integration will detract quality of services; and (4) whether integrated services are cost-effective. In addition to these specific questions, practitioners, managers, and technical experts have raised issues such as clarity of language around concepts such as integration and linkage; which service gets integrated into what; and how to address the logistical, training and equipment needs of different services and programs.

Many of these questions have remained unanswered in part, because of lack of assessment methodologies that could generate the information. In this paper, we describe a methodology that was specifically designed to measure the integration of services including assessing quality of care. We provide illustrations of the use of this methodology in diverse program settings in Africa, Asia and Latin America and conclude with a summary of the experience—both the successes and challenges and implications for research design.

Hypothesis or Activity Tested

AIM builds on the Situation Analysis methodology, devised by the Population Council in the 1990s, to better understand the range of programmatic factors that influence the quality of care during facility-based family planning services (Miller et al., 1997; Miller et al., 1998). AIM continues to be a health facility based assessment with particular focus on integrated services.

Assessing Integration Methodology (AIM)

AIM combines quantitative and qualitative features and collects information about: facility infrastructure; provider attitudes, training and behavior; client perceptions of care received; client flow; and cost information.

AIM has been tested in over fifteen projects in a dozen countries over the past decade. It has been used to assess integration of the following service combinations: family planning, specific components of MCH such as antenatal, delivery and postnatal care, and HIV/STI; family planning and postabortion care; family planning and HIV counseling and testing.

Summary of Experience or Findings

In summary, the experience thus far is that the methodology is able to measure the type and level of integration. Further, it can generate both quantitative indicators as well as qualitative information to shed light on the process of integration. AIM can be feasibly implemented in field situations across a range of program settings with a low refusal rate of participation. Challenges that remain include: balancing focus between the integrated service versus the individual component of the service package; the choice of sampling frame; and the level of aggregation required for analysis for research and programmatic purposes.

Knowledge contribution

This new tool is useful for documenting the model of integration and its feasibility, identifying the model’s weaknesses, providing crucial information useful for hypothesis testing, and generating information to guide programmatic action including replication and scale-up.
Religiosity, Sexual Debut and Contraceptive Use among In-School Adolescents in Lagos State, Nigeria

Olayinka Yetunde Asubiaro, Adesegun O Fatusi, Uche Omwudiegwu
Obafemi Awolowo University, Ile-Ife, Nigeria; yinkasaubiaro@yahoo.com

BACKGROUND

High level of unprotected sex among Nigerian adolescents is associated with high level of reproductive health problems. This study assessed previous sexual experience and contraceptive use among in-school adolescents in Lagos State, Nigeria. It further assessed the level of internal and external religiosity and their association with sexual debut and contraceptive use.

INTERVENTION/ACTIVITY TESTED

The study assessed the level of internal and external dimensions of religiosity among in-school adolescents in Lagos State, Nigeria. It further determined sexual debut patterns among in-school adolescents and assessed the pattern of contraceptive use among sexually experienced in-school adolescents. This was with a view to determine the relationship between religiosity and sexual behavioural pattern (sexual debut and contraceptive usage) among the in-school adolescents.

METHODOLOGY

The study was cross-sectional in design and was carried out in three Local Government Areas, representing each of the three senatorial districts of Lagos State. Data was collected through 72-item self-administered questionnaires eliciting responses on socio-demographic information, knowledge on reproductive and sexual health, sexual behaviour and contraceptive use pattern, and the internal and external dimensions of religiosity levels. Univariate, bivariate (χ2 for contingency tables and Mann-Whitney U test), and multivariate analyses were carried out using SPSS. Binary logistic regression was used to assess the association between religiosity (a dichotomised variable) and sexual experience and contraceptive use. Cox proportional hazards regression was used to assess the association between age of sexual debut and religiosity. Odds ratio (OR) and Hazard ratio (HR), 95% confidence interval (CI) and p-values were calculated separately for males and females.

FINDINGS

A fifth of the adolescents (males: 26.6%; females: 19.8%) were sexually experienced (p<0.004). A significant higher proportion of male respondents reported modern contraceptive methods use than females at both sexual debut (50.5% vs. 38%; p<0.035) and currently at the time of study (50.4% vs. 32.3%; p<0.002). A significantly higher proportion of late adolescents (15-19years) compared to early adolescents (10-14 years) reported modern contraceptive methods use at sexual debut (50.9% vs. 33.2%; p<0.003) and currently at the time of study (47.2% vs. 32%; p<0.012).

Bivariate analysis showed that higher level of internal religiosity was significantly associated with delayed sexual initiation among males (p=0.017) and females (P<0.001). External religiosity, on the other hand showed a significant negative association with sexual initiation among adolescent males (p=0.007) but not among females (p=0.665). In multivariate analyses, external religiosity was associated with a greater likelihood to delay sexual debut among only adolescent males (OR =0.603, 95% CI=0.398-0.914), while internal religiosity was associated with a greater likelihood to delay sexual debut among only the females (OR =0.557, 95% CI = 0.355-0.876). Age was also significantly associated with adolescents sexual initiation among both males (HR=1.11, 95% CI=1.001-1.24) and females (HR=1.26, 95% CI=1.11-1.42). However, the association between age and contraceptive usage was significant only among female respondents (OR=0.66, 95% CI=0.45-0.95). While early pubertal development among females was about seven times associated with pattern of contraceptive use (OR=2.71; 95%CI=0.10-7.33) as well.

KNOWLEDGE CONTRIBUTIONS

Religiosity showed significant association with sexual behaviour of adolescents which however, varied by gender and should therefore constitute an important focus in programming for adolescent health in Nigeria.

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

Susan Igwe, Rebecka Lundgren, Sujata Bijou, Marie Mukubatsinda, Elizabeth Salazar
Institute for Reproductive Health/Georgetown Univ, United States of America; smi6@georgetown.edu

Background/Significance

The 10-14 year old period represents a critical time in adolescent development. The societal messages that children are acquiring about their bodies and body functions will influence them throughout their lifetime. Between the ages of 10 and 14, boys and girls are beginning to solidify their sexual and gender identities and develop attitudes and skills that lay the foundation for future sexual and reproductive health and well-being. While the critical importance of adolescent sexual and reproductive health is well recognized, programs reaching very young adolescents (VYAs) aged 10-14 remain underdeveloped. Likewise, research tools and methodologies to evaluate the impact of programs reaching VYAs remain underdeveloped.

Hypothesis/Intervention/Activity Tested

“My Changing Body” (MCB), a six-session course, based on youth participation in a series of activities and discussions, addresses gaps in life skills and materials for use in these programs. It helps boys and girls aged 10-14 become body literate, that is, understand, through participatory exercises, the physical, emotional, and social changes/changes in societal expectations that occur during puberty. MCB also helps girls and boys understand the basis for their sexual and reproductive health - fertility awareness. Occasional home activities promote parent-child communication on sexual and reproductive health-related issues. A companion course helps parents understand puberty-related issues that their children are facing and ways to support them.
The MCB course was field tested and evaluated in two country sites and programs – APROFAM in Guatemala and Catholic Relief Services in Rwanda - to assess the usefulness of integrating MCB concepts into existing youth-serving organizations.

Methodology

Formative research to revise the MCB course involved focus groups with 10-12 and 13-14 year boys and girls, parents, and teachers and community leaders in Guatemala, Madagascar, and Rwanda. Facilitated discussions with adolescents were centered around diverse activities such as community mapping, storytelling, and creating collages.

Based on results, the MCB exercises were adapted and integrated into on-going life skills education offered by APROFAM and CRS.

The intervention was evaluated by local research groups in collaboration with IRH, using a post-test only control group design. Pre and post intervention measurements, qualitative and quantitative, were made of knowledge, awareness, attitudes, and behaviors.

Working with young adolescents required development of tools that would elicit responses of young people who, because of their age and developmental stage, would not be necessarily respond well in focus group discussions or through answering survey-type questionnaires. Tools were adapted from field-tested Participatory Learning and Action (PLA) exercises such as ‘My Universe.’ Simple Likert scales were created, using picture instead of number scales. New tools were developed and tested including card games and pile sorts. Respondents were asked to draw and talk about pictures, complete storylines, and comment on photo series.

Findings

Findings from the formative research revealed low knowledge of fertility and reproductive processes and low comfort with puberty-related changes. Traditional gender roles influenced perceptions regarding puberty and how parents and adolescents responded to changes that occur during puberty. There was also a need to sensitize parents and the general community about puberty, gender roles, how they intersect, and to offer skills-building activities to help parents create more supportive environments. Findings from the end-of-intervention evaluation research revealed important changes in knowledge, awareness, attitudes, and behaviors of adolescents and their parents.

The developmental stage of very young adolescents necessarily influences research study designs and methodologies. Guidelines on ethics of working with VYAs have been more widely documented in the literature than guidelines on tools and research methodologies that are most appropriate for this age group. IRH established clear guidelines for consent and established referral systems in cases when violence against children was suspected. Use of games and participatory exercises to engage adolescents physically and then discuss their visual outputs worked well, although some activities worked better than others for the 10-11 year old sub-group. Using such tools allowed us to gather information on knowledge and self-care behaviors as well as on intangible but developmentally-important changes, such as comfort with one's body image.

Knowledge contribution/Lessons learned

The 10 –14 year old years are transformational -for girls and boys -for establishing body awareness, gender, and sexuality attitudes towards self and others and an optimal time to provide correct information about the body that helps create a foundation for future sexual and reproductive health and well-being. Low technology, participatory approaches, based on equity of girls and boys to having correct information of fertility, body changes, and gender and sexuality, worked well. Concurrent evaluation tools and methodologies, inspired from a variety of social science and development disciplines, allowed for evaluation of a variety of changes in addition to standard knowledge and behavior outcomes.

A04: 3

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.

Esther Babirey Kaggwa, Michelle Hindin
Johns Hopkins University, United States of America; ekaggwa@jhsph.edu

Background/Significance

In many African countries, including Uganda, young people comprise a significant proportion of the total population. Although, the research on the role that individual factors play in influencing contraceptive use among youth has been building over the past few years, evidence on the effect of the family and school on such behavior remains limited. Little has been done to explore the effect of parental behaviors on knowledge or use of pregnancy prevention methods. Additionally, while research has shown that school attendance generally improves use of a method, the specific characteristics of the school that influence this decision are not fully known. In addition to exploring patterns around knowledge and use of pregnancy prevention methods, this study sought to examine the role that specific family and school factors play in this knowledge and use.

Hypothesis or Intervention/Activity Tested

Hypothesis 1: Young people whose parents communicate more on issues of sex and HIV, those with a higher level of parent monitoring and those with a lower level of parent permissiveness are more likely to know more methods and are more likely to report using a method at first sex

Hypothesis 2: Youth attending schools with a more health information sources as well as those in better performing schools are more likely to know more methods of pregnancy prevention and are more likely to report use of a method at first sex.

Hypothesis: The school environment generally influences number of methods known as well as use of a method at first sex.

Methodology

The research comprises of a cross-sectional study of young people attending 10 randomly selected secondary schools in Mukono Township, Mukono district in Uganda. All students between form three and six were eligible to participate. We conducted univariate, bivariate and multivariate methods to assess the patterns around knowledge and use of pregnancy prevention methods. Multivariate analysis focused on two outcomes; the number of pregnancy prevention methods known and use of a method at first sex. A random intercept was put on school to accommodate clustering by school and assess if unmeasured aspects of the school environment influence these outcomes.

Data

. The analysis on number of methods known included all 1500 students in the survey while examination of use of a method at first sex included the 619(41.3%) students who had initiated sex by the time of the survey.

Findings
Knowledge of at least one modern method to prevent pregnancy was nearly universal (88.2%). The condom was the most commonly known method (72.7%), followed by the pill (38.9%). A majority of young people reported that they first heard of methods on the radio or television. Fear of side effects (43.2%) followed by fear of what other people would say (24.9%) were the most commonly reported reasons as to why young people do not use contraception. Only 10.0% of youth reported not knowing where to get a method as a reason for young people not using pregnancy prevention methods.

Slightly more than 40% of young people were sexually experienced. The condom was the most ever used method (used by 75.9% of youth), followed by the pill (6.95% of youth). Overall, 73% of youth indicated they had used a method to protect against pregnancy the first time they had sex, with the condom being the most favored method of choice at first sex.

Multivariate analyses showed that higher parent child communication on sex/ HIV (OR; 1.12) and a higher level of parent monitoring (OR= 1.08) were associated with higher use of a method at first sex. Students attending better performing schools (OR=2.17) were more likely to use a method at first sex.

The data also showed that older students knew of more pregnancy prevention methods (b=0.064), while students with a higher parent permissiveness score (b=0.06) as well as those with a higher level of communication on sex or HIV with their parents/guardians knew of fewer methods (b=0.03). The number of school sources for health information or attendance at a better performing school was not associated with number of methods known. However, the random intercept for number of methods known was significant indicating that other unmeasured aspects of the school environment explain some of the variation in number of methods known.

Knowledge Contribution or Lessons Learned

The study seems to suggest that the family and school have a differential effect on the knowledge and use of contraceptive methods among young people. While existing research has shown that school attendance increases the use of family planning methods, this study seems to suggest that among school going youth, characteristics may not contribute significantly to whether or not a young person uses a method at first sex, although they may influence knowledge of these methods. However, a number of family characteristics may play a major role in a young person’s decision to use a method at first sex.

A04: 4

Evaluation of Community-Based Youth Reproductive Health Communication Intervention in Bihar for Evidence Based Advocacy and Scale Up

Elkan Elijah Daniel, Rekha Masilamani, W. Sita Shankar
Pathfinder International, India; eedaniel@pathfind.org

1. Background/Significance

Since 2001, Pathfinder International/India has implemented the Promoting Change in Reproductive Behavior (PRACHAR) Project in over 700 villages in 5 districts of Bihar. The goal was to reduce young adult fertility through changing social norms related to early child bearing and inadequate child spacing specifically by delaying the first child until the wife is 21, spacing the second child by 36 months, and increasing contraceptive use by young couples. Every cluster in the intervention sites was exposed to 3 years of uniform intervention resulting in significant increases in RH knowledge and contraceptive use among couples with 0 & 1 parity. The results of Prachar Phase I were published in the December, 2008 issue of International Family Planning Perspectives.

The Integrated package of comprehensive intervention included:

- Environment building to change social norms
- Behavior Change Communication to educate young adults about delaying 1st birth and spacing 2nd birth
- Improving access to contraceptives and RH services through support to health providers.
- Capacity building of NGOs for RH programming

2. Research: State main question/hypothesis

From July 2006 to March 2008, Prachar Phase II intervention in all clusters addressed the following research questions and provided scientific bases for decisions concerning scaling up of Prachar approaches and understanding its impact in Bihar. Seven intervention models were developed along with two comparison areas.

Question Intervention model

What happens to behavioral outcomes if the intervention is continued for 2 more years? 1. Continuation of comprehensive intervention of Phase I

What is the effect of discontinuing the intervention? 2. Discontinuation of comprehensive intervention

Can trained and committed volunteers affect behavior change as effectively as a group of paid NGO staff? 3. Voluntary contraceptive counselors only in intervention areas

Will the comprehensive intervention have the same impact on behavioral outcomes if implemented for a shorter period of time? 4. Comprehensive intervention for 24 months in four new communities

What impact on behavioral outcomes do selected components of the intervention have? 5. Home visits

6. Training

7. Voluntary contraceptive counselors (VCC)

3. Methodology (including location, setting, period, analysis approach)

A quasi-experimental program trial design was used. Community surveys were conducted at baseline and follow up. Respondents were selected randomly in intervention areas in Nalanda, Nawada, Patna, Gaya and Sheikhpura districts of Bihar with representativeness based on village size, geographical location, age, sex, marital status, parity and demographic composition. Comprehensive MIES and analysis of longitudinal monitoring data was used. Analysis compared
differences in behavioral outcomes. Logistic regression methods were used to assess the effect of intervention on the indicators. Survival analysis was used where applicable.

An adolescent 5-year follow up study was carried out to determine whether training received as an adolescent contributes to delaying age of marriage and first birth and increased contraceptive use.

Sample size for community survey was 26,400 respondents and 600 for the adolescent study.

4. Data (if relevant)
5. Findings

Summary findings: effect on contraceptive use

Intervention model Parity Zero Parity One
1. Comprehensive intervention continued Use stabilizes at 25% Use continues to increase from 46-53%
2. Comprehensive intervention discontinued Initial decline but stabilized afterward Initial decline but stabilized afterward
3. Comprehensive intervention discontinued, VCC added Same as discontinued model Same as discontinued model

4. Comprehensive intervention for
24 months Use increased in 3 yrs from 9 to 25%
Use increased in 2 yrs from 5 to 15%
3 yr > 2 yr. Use increased in 3 yr from 18 to 39%
Use increased in 2 yr from 13 to 32%
3 yr > 2 yr.

5. Home Visits Use increased from 7 to 21% No increase
6. Training Use increased from 6 to 15% No increase
7. VCC Use increased from 5 to 12% No increase

Adolescent study findings:
• Median age at marriage was 22.3 yrs for boys and 20.9 yrs for girls in intervention areas and 21.3 yrs. for boys and 19.4 yrs. for girls in comparison areas
• Median age of women at 1st birth was 23.6 yrs in intervention areas - 2 years higher than in comparison area. Using Bongaarts model, this shows that the project has achieved a 21% reduction in population momentum.

6. Research: State knowledge contribution

Evidence demonstrated that: culturally appropriate community-based communication increases contraceptive use; greater behavior change occurs over 5 years than in 2 years, and it improves with the implementation of each additional intervention activity; home visits were the most effective single intervention; husbands play significant roles in determining contraceptive behavior; adolescent training before marriage significantly influences behaviors during marriage; and it is imperative to address issues of youth fertility.

Prachar Phase III will be launched in September 2009 using the evidence-based intervention design and taken to scale in one entire district of Bihar.

AO4: 5

Adolescents living with HIV require sexual and reproductive health information and services

Harriet Birungi1, Francis Onyango1, Juliana Nyombi2, Hannington Nyinakau2

1Population Council, Kenya; 2TASO, Uganda; hbirungi@popcouncil.org

1. Background/Significance

In HIV/AIDS treatment, care and support programming, concern for the vulnerability of young people to HIV infection tends to overwhelm some of the more positive realities of sexuality, which is an equally important part of growing up. In Uganda and elsewhere in sub-Saharan Africa, wide programmatic gaps exist in addressing sexual and reproductive health needs of young people infected with HIV who are now growing into adolescents and adults. The almost exclusive focus on the negative implications of HIV tends to hinder initiation of programmes aimed at addressing the sexuality desires of young people living with HIV. This problem is compounded by the false assumption that young people (10-19 years) living with HIV in Africa may be too few to justify targeted programming and a reluctance to acknowledge that it is natural for them to have sexual needs and desires and to act upon them. Many young people living with HIV aspire to be just like their peers who are HIV negative. Therefore, it can only be anticipated that these young people as well desire to explore their sexuality and would therefore benefit from sexuality education and services.

2. Methodology (including location, setting, period, analysis approach)

The AIDS Support Organization (TASO) in Uganda supported by the Population Council’s initiated a diagnostic study in 2007 to understand the sexual and reproductive health needs of adolescents born with HIV. The study involved qualitative research and a survey of 732 perinatally HIV-infected girls and boys aged 15 to 19 years. Its aim was to better understand the sexuality (desires, experiences, beliefs, values and practices) of this group of the population, and to identify anxieties or fears they have around growing up, love and loving, dating, pregnancy, fatherhood, motherhood, relationships and intimacy. This paper describes some of the key findings from this study and discusses the implications of the findings for programming.

3. Findings

Fifty two percent of the respondents were currently in a relationship while 33% reported having had sexual intercourse. Forty percent reported a desire to have sex and 41% felt that there is no reason why someone who is living with HIV should not have sexual intercourse. In terms of preventive practices, only 37 percent of the respondents who had ever had sex reported using a preventive method at the time of first sex to prevent HIV infection. In addition, one half of those who had ever had sex used any form of contraception in their current and previous relationship. When asked about their worries, many adolescents living with HIV seemed most worried about becoming pregnant rather than being HIV positive. Forty one percent of the sexually active female adolescents had ever been pregnant.
4. Research: State knowledge contribution

The findings of this study were intended to provide a better understanding of the sexual and reproductive health concerns of adolescents perinatally infected with HIV, and to identify and develop interventions that integrate SRH issues for such adolescents into the existing HIV/AIDS treatment, care, and support programs that serve them. A key finding is that infected adolescents aspire to live their lives just like their peers who are not HIV-infected. This study confirms that there exist wide programmatic gaps in addressing the sexual and reproductive health needs of young people adolescents infected with HIV who are now growing into adolescents and adults. This evidence provides, therefore, a concrete basis for generating discussions on how existing programs could be strengthened to provide young people with appropriate information and services.

**B04: Assessing the Costs and Benefits of Providing Sexual and Reproductive Health Care**

**Time:** Monday, 16 November 2009: 4:00pm - 5:30pm

**B04: 1**

**Adding It Up: The costs and benefits of interventions in sexual and reproductive health in Ethiopia**

Aparna Sundaram1, Michael Vlassoff2, Lisa Remes2, Akinrinola Bankole2

1Unknown; “Guttmacher Institute, USA; sshaw@ippf.org

**Introduction:**

The inability of the Ethiopian government to make needed investments in meeting their health MDG goals, in particular those relating to sexual and reproductive health, has become an obstacle to ensuring the health and wellbeing of mothers and children in the country. A consequence of this is that a large proportion of Ethiopian women end up with unintended pregnancies that in turn result in higher rates of maternal and infant mortality and morbidity, and put more pressure on an already overburdened health system.

A 2003 report called “Adding It Up” published by Guttmacher and the UNFPA estimated that it was cheaper for developing country governments to invest in sexual and reproductive health services in order to reduce their health bill in the long term due to the benefits that would follow. The report showed that with reduced unintended pregnancy, there would be reduced maternal and infant mortality and morbidity, and reduced abortions all of which would alleviate the health burden on the country and have various beneficial results for the society as a whole. In this paper we will be using the techniques and methods of the “Adding It Up” report to estimate the costs and benefits of providing sexual and reproductive health services including family planning services to the Ethiopian government.

**Methods:**

We will be using data from the most recent Ethiopian census, including projections data; data from the most recent 2006 Ethiopia Demographic and Health Survey; recent estimates from the United Nations; abortion data from Guttmacher, and published estimates from various country reports to arrive at the monetary cost of providing sexual and reproductive health services in Ethiopia. We also estimate the monetary benefits to Ethiopian society in terms of reduced maternal and infant mortality and morbidity, reduced unsafe abortions, and reduced DALYs (disability-adjusted-life-years).

We will examine costs and benefits for four scenarios: the first scenario looks at costs and benefits of providing no contraceptive services. The second scenario shows the costs and benefits associated with the current level of contraceptive use where some of the demand is satisfied, but substantial unmet need still exists. The third scenario will mirror the government’s strategy of increasing the use of long-acting contraceptive methods by assuming a method-mix favoring long-acting methods; and the fourth scenario examines the costs and benefits associated with satisfying all current unmet need for contraception.

Each set of results will also be presented by wealth status and by region since sub-group analysis can help reveal any structural inequalities in the provision of reproductive health services.

**Results:**

The paper will present the 2008 estimates of women at risk of unintended pregnancies, unintended and intended births, induced abortions, and miscarriages. The costs of providing sexual and reproductive health services that would reduce the health burden to the country are provided. Importantly, the benefits in terms of maternal and infant deaths averted, DALYs reduced, and abortions and unintended pregnancies avoided, are also provided. All results will be shown by wealth status and by region.

**Conclusions:**

We hope to show that the investments in sexual and reproductive health services in Ethiopia will be more than off-set by the increased benefits to Ethiopian society by the reduction of the health burden. Based on our findings we will make program and policy suggestions for the improvement of sexual and reproductive health services in Ethiopia. The findings from this study should encourage the Ethiopian government to invest more in these services for the benefit of Ethiopian society as a whole.

**B04: 2**

The human and Economic impact of RH supplies and shortage and stock outs in Bangladesh

Abul Barkat

IPPF, United Kingdom; sshaw@ippf.org

This ground-breaking study is the first analysis of the human and economic impact of shortages of RH supplies in Bangladesh. The study was commissioned by the Family Planning Association of Bangladesh and carried out by the Human Development Research Centre Bangladesh. It was conducted as a response to a lack of a credible evidence base for advocates advocating for increased contraceptive security in Bangladesh.

The study covers the period from November 2007 to October 2008, and focuses on condoms, pills and injectables. The study has three objectives. 1.) To assess the human impact of stock outs, shortages and irregular supply of contraceptives. This includes the physical and psychological effects, and the impact on household income as a consequence of stock outs, shortages and irregular supply of contraceptives. 2.) To assess the impact on national economy in terms of hours of labour lost; the monetary value of this and the additional medical costs at national level. 3.) To ascertain the trends, sufficiency and priority for allocation of funds for reproductive health (RH) and RH commodities and how the funds are utilized.

The methodology was comprised of qualitative and quantitative tools. Core research with users of condoms, oral contraceptives and injectables at thirty Family Welfare Assistant Units, across six divisions, who have experienced at least one shortage stock out or irregular supply during the year preceding the survey (i.e. March 2008-February 2009). Data collection tools used were a balance of qualitative and quantitative tools: Individual interviews with 2,756 users of the three
contraceptive methods; individual interviews and focus group discussions with 205 users of contraceptives who have experienced stock outs, shortages and irregular supply; group discussions at district level, Director General of Family Planning, and analysis of government stock levels through ‘Formats.’ The focus group and group discussions provided qualitative data. Quantitative data was gathered via the individual interviews and data obtained through the government ‘Format reports.’ The initial interviews of 2,756 users of contraceptives were carried out to identify the sample group of 205 individuals who had experienced stock outs, shortages or irregular supply of contraceptives. This was supplemented by a review of government data gathered via ‘Formats.’ and analysis of the data from Family Planning Monthly Logistics Report of Directorate General of Family Planning. This enabled diagnosis of the stock out situation due to shortages of contraceptives flowing through government channels. All information collected was triangulated at district level in the presence of local health and family planning managers to validate the findings.

Key research findings for objectives 1 and 2 include: About 12 percent users of oral pill, injectable and condom experienced irregular supply/shortage stock-out during the last year. A 7.4% of all users of these three family planning methods suffered due to irregular supply. 10 per cent of the users who had experienced shortages or stock outs experienced unintended pregnancy. The average loss of net income per suffering household due to shortage/stock out/irregular supply of the three family planning methods came to 1,026 BTK (US$15). Of this group 50 per cent had an annual household income of $726 or less. At national level the cost to the national economy was 4,275 million hours. In monetary terms this is equivalent to US$870 million.

Findings for objective 3 indicate that since 2005 the allocations of resources for family planning have been erratic. Between fiscal years 2005-06 and 2007-08 it increased by 24.4%. By FY 2007-08 it had declined by 21.26%. The purchase of contraceptives remains entirely donor funded while government revenue is used to supplement donor funds to support the family planning programme.

This study represents the first time the impact of contraceptive insecurity has been framed in terms of financial cost at household level and to the national government. It also provides the evidence for the causes of contraceptive insecurity. The study identifies that although funding patterns for contraceptives are erratic and future funding uncertain. Currently there are adequate funds to meet need. However, the lack of a functioning supply chain and adequate forecasting mechanisms inhibits the government’s ability to maximize the funds ensuring they are supporting an effective family planning programme which procures and distributes enough contraceptives to meet the need, and has mechanisms to ensure they reach everyone who needs and wants contraception.

This research forms the evidence base for a number of recommendations which, if implemented could help revitalize the family planning programme of Bangladesh and reverse the current decline in contraceptive prevalence. Recommendations from the research include: The need to streamline the procurement system – currently there are nineteen stages in the process and this takes a minimum of 18 month to complete. Establish a sound monitoring system and a forecasting mechanism for procurement and supply. Allocate funding from revenue budget to reduce donor dependency.

**B04: 3**

**Adding It up: the costs and benefits of interventions in sexual and reproductive health in Uganda**

Michael Vlassoffo1, Apanna Sundaram1, Frederick Mugisha2, Lisa Remez1, Akinrinola Bankole3

1Unknown; 2Economic Policy Research Center; 3Guttmacher Institute, USA; sshaw@ippf.org

**Introduction:**

Unacceptably high levels of maternal and infant mortality and morbidity are a source of continuing concern in Uganda. In 2005 Uganda lost about 550 mothers per 100,000 births to pregnancy related complications; and in 2009 about 84 babies per 1000 babies born alive died before reaching their first birthday. In a country where about 30% of the women of reproductive ages report having more pregnancies than they intended, improvements in maternal and child health will depend on the ability of women to have adequate access to sexual and reproductive health services including access to contraceptives. Adequate access to family planning services will allow women to reduce unwanted pregnancies thereby reducing adverse consequences related to pregnancy and child bearing.

An important concern in developing countries like Uganda has been the availability of economic resources to provide such services to women. A 2003 report “Adding It Up” published by the Guttmacher Institute and the UNFPA showed however that it was cheaper to invest in these services given the benefits in terms of reduced mortality and morbidity for the country, and importantly reduced expenditure in such services in the long-term. In this paper we will apply the techniques of the “Adding It Up” report to the Ugandan context to estimate the costs and benefits to the Ugandan government in investing in sexual and reproductive health services.

**Methods:**

Data from the Uganda census projections, the 2006 Uganda Demographic and Health Survey, the most recent demographic estimates from the United Nations, abortion data from the Guttmacher Institute, and various recent country reports, will be used to estimate the monetary costs of providing sexual and reproductive health services in Uganda and also the monetary savings in terms of reduced maternal and infant mortality, unsafe abortions, and DALYs (disability-adjusted-life-years).

We will examine costs and benefits for four alternative scenarios: the first scenario looks at costs and benefits of providing no contraceptive services. The second scenario shows the costs and benefits associated with the current level of contraceptive use where some of the demand is satisfied, but substantial unmet need still exists. The third scenario shows the costs and benefits of satisfying about 50% of the current unmet need for contraception, paralleling closely an objective of the government’s current health strategy; and the fourth scenario examines the costs and benefits associated with satisfying all current unmet need for contraception.

In order to examine if there are any structural inequalities in the provision of reproductive health services, results will be disaggregated by wealth status and by region.

**Results:**

The paper will present the most recent estimates of women at risk of unintended pregnancies, unintended and intended births, induced abortions, and miscarriages. The costs of providing sexual and reproductive health services that would reduce the health burden to the country are provided. Importantly, the benefits in terms of maternal and infant deaths averted, DALYs reduced, and abortions and unintended pregnancies avoided, are also provided. All results will be shown by wealth status and by region.

**Conclusions:**

Based on our findings we will show that investments in sexual and reproductive health services, which may look heavy in the short-term, will actually bring net benefits to Ugandan society in terms of improved mother and child health. Additionally, the bill to the exchequer will also reduce as the health burden decreases. The paper concludes with suggestions for policy and program actions to further encourage the Ugandan government to invest in this sector.

**C04: Psycho-social Aspects of FP II**
CO4: 1

Contraceptive practice prior to female sterilization in Ghana: 1996-2005

Hilary Megan Schwandt, Andrea Creanga, Kwabena Antwi Danso, Frank Ankobea-Kokroo, Cornelius Archer Turpin, Michelle Hindin

1Johns Hopkins Bloomberg School of Public Health, United States of America; 2Kwame Nkrumah University of Science and Technology School of Medical Sciences, Kumasi, Ghana; hschwand@jhsph.edu

Background/Significance

According to the Ghana Demographic and Health Survey (DHS), in 1988 the prevalence of modern contraceptive use in Ghana was a mere 5%. Between 1988 and 1998 the use of modern contraceptive methods in Ghana nearly tripled, from 5% to 13%. The 2003 Ghana DHS indicates that 25% of women in Ghana were using a method of family planning, while 19% of them were using a modern contraceptive method. Preliminary results from the Ghana 2008 DHS indicate that modern contraceptive use has actually decreased from the 19% reported in 2003 to 17% five years later.

About 1% of Ghanaian women reported relying on female sterilization to avoid a(nother) pregnancy in 2003, while male condoms, pills and injectables were each used by some 4% of the female population of reproductive age. Thus, relative to other available contraceptive methods of lower use-effectiveness, sterilization is a somewhat important contributor to the contraceptive prevalence rate in Ghana.

Who are these women obtaining tubal ligations, were they users of other contraceptive methods prior to being surgically sterilized? Has the profile of this patient population changed over time?

Hypotheses

This analysis aims to provide a profile of women who obtained sterilization at Komfo Anokye Teaching Hospital in Kumasi, Ghana between 1996 and 2005. Specifically, we examine the differences between women who have and have not used contraception prior to sterilization, and between two time periods: 1996-2000 and 2001-2005.

Methodology and Data

We use data from medical records of 1,874 female sterilization clients who opted for a tubal ligation at the Komfo Anokye Teaching Hospital in Kumasi, Ghana between 1996 and 2005. We conducted bivariate analyses to characterize this patient population. Logistic regression models are fitted to further examine these patients’ prior use of other contraceptive methods. The full models adjust for the year of the procedure (1996-2000 or 2001-2005), socio-demographic and partner-related characteristics, as well as knowledge of contraception and use-related variables.

Findings

Overall, 55% of the patients in our sample had used a modern contraceptive method prior to sterilization. We find that the time period when the procedure was performed, the number of family planning methods known, the age of the partner, women’s parity, religion, main source of information about sterilization, and the time since the woman first heard of this method are all predictive of contraceptive use prior to female sterilization. In the models stratified by year of procedure 1996 – 2000 and 2001 – 2005, we find that parity, the number of family planning methods known, and time since first heard of sterilization are all predictive of prior use of another modern contraceptive method for women who obtained a tubal ligation between 1996-2000; however, only time since first heard of the procedure and the main source of knowledge on sterilization are predictive of prior contraceptive method use for women sterilized between 2001 - 2005.

Knowledge Contribution

These results can be used to target family planning efforts at individuals who are unlikely to use contraceptive methods for spacing prior to female sterilization. Targeting this vulnerable, potentially accessible, population is especially important in preventing mistimed pregnancies and unsafe abortions in Ghana - where complications from unsafe abortion are the leading cause of maternal death.

CO4: 2

"Pages Of Life" - Research on the Impact of Social Merchandising

Marcio Ruiz Schiavo, Scott Connolly

1Comunicarte, Brazil; 2Population Media Center, US; mschiavo@comunicarte.com.br

(1) Background/Significance

Soap operas and telenovelas have always fascinated educators and communicators for their ability to attract large and loyal audiences. For the purposes of promoting family planning, this medium has proven itself to be particularly powerful because the lives of characters in the dramas can serve as a mechanism for addressing and questioning sensitive issues in viewers’ lives without seeming too invasive or exhortative. Televised dramas have the added advantage of reaching people in the home where many of life’s decisions and behaviors occur.

As an innovative strategy of education directed at large audiences, social merchandising consists in a systematization and insertion of educational messages into different media, including soap operas. Brazilian telenovelas have already served as basis for introducing a range of social questions and issues from unemployment, unrecognized paternity, and abandonment of children, to premature marriage, and divorce. With a basis in social merchandising, the methodology of interaction with these social issues can be systematized, beginning with the pre-production phase through the broadcast and dissemination phase of a drama. This methodology involves the intentional insertion of social messages into the plot of soap operas – in the lives of the characters, which allows characters to be opinion leaders who introduce sociocultural innovations.

Social merchandising in telenovelas can address different health and social issues, including family planning, sexual and reproductive health, gender relations, prevention of drug abuse, prevention of STIs/HIV/AIDS, sustainable development and other themes salient to various segments of the Brazilian population. For the viewer, change begins with the acquisition of new knowledge learned vicariously through a drama which enables reflection on individual attitudes, behaviors and practices. In turn they may adopt positive changes in the present or in the near future.

In Brazil, television has the largest reach of any medium: a recent study estimates that there are currently 54 million TV sets in Brazil. And broadcasts cover almost the entire national territory. Thus, nearly the entire population has access to television. Rede Globo, the largest broadcast network in the country, is received in 98% of Brazilian municipalities.

(2) Intervention/Activity Tested
Over the last 20 years, all social merchandising actions introduced in Rede Globo’s soap operas have been monitored and evaluated by Comunicarte, Population Media Centers’ (PMC) partner in Brazil. In the last 16 Rede Globo productions, 308 scenes with content related to family planning have been verified and analyzed by Comunicarte. Páginas da Vida “Pages of Life” is one of these recent productions. This drama addressed sensitive societal issues, including family planning, unwanted pregnancy and HIV prevention.

To assess the social impact of the social merchandising actions included in the Pages of Life, a comprehensive study was conducted by Comunicarte with support from PMC. The objective of the study was to scientifically measure the contribution of the actions of social merchandising as a result of the drama. Specifically, the research was designed to test the hypothesis that socioeducational scenes presented in the soap opera exercise a positive influence on the knowledge, attitudes, behaviors and practices of regular viewers. This included determining levels of knowledge of people and communities on specific questions related to family planning, adoption of new attitudes, behaviors and practices that are positive and protective based on the principle that, in general, the levels of family planning and personal care of the individuals varies based on the levels of knowledge, motivation and involvement with the question.

(3) Methodology
To gather data, structured interviews using questionnaires designed to capture knowledge, attitudes, beliefs, and practices towards family planning and sexual and reproductive rights were conducted by interviewers specifically trained to conduct the survey by experts of the executing organizations of the study. A total of 675 interviews were conducted during the years of 2006 and 2007 in Brazil.

(5) Findings
The results demonstrated that a large majority of regular viewers of Páginas da Vida recall having seen scenes addressing the issues of reproductive health (67%), family planning (42%) undesired pregnancy (84%) adolescent pregnancy (86%), prevention of HIV/AIDS (90%) abortion (67%) and other issues. In many cases, respondents reported that their knowledge of these issues increased, and that their attitudes changed positively in relation to the information received. For example two thirds of women (65,4%) who were regular viewers said that “they began to pay more attention to avoid getting pregnant” as a result of watching Páginas da Vida. The study also found that more than half (56.3%) of those interviewed were motivated by the program to seek reproductive health or family planning services.

(6) Knowledge Contribution or Lessons Learned
The study confirms that social merchandising is an effective method for promoting individual behavior and attitude change. Certainly, social merchandising alone will not solve all of the socioeducational problems present in Brazilian society. However, its contribution towards the betterment of Brazilian society is already substantial, and it is being replicated throughout other world mass-media vehicles that can contribute to a development of social change with realism, ethics and responsibility.

**CO4: 3**

**Finding the right messages about the IUD**

**Claire Stokes, James Kajuna, Risha Hess**  
PSI Tanzania, Tanzania; cstokes@psi.or.tz

1. Background

Tanzania has a contraceptive prevalence rate of 20%, with the most popular methods being oral contraceptive pills (5.9%) and injectables (8.3%). Long-term methods, especially the IUD are vastly under-utilized: the 2004 DHS reported only 0.2% of women using the IUD.

According to reports, various myths exist about the IUD. These myths, for example, babies born with the IUD in their hand, likely act as barriers preventing uptake of the IUD.

PSI/Tanzania received funding to promote long-term contraceptive methods and therefore sought to find out what the most effective messages to potential users would be.

2. Research question:

PSI wanted to investigate why women do or do not accept contraceptive methods, specifically the IUD, in order to determine the most effective messages and interventions for increasing their use.

3. Methodology (including location, setting, period, analysis approach)

PSI conducted two studies; a quantitative study in November 2008 of 2,000 women of reproductive age to investigate key determinants of modern contraceptive use. This study was conducted nationally through household visits randomly selected throughout the country to be representative of the population of Tanzania.

A qualitative study was conducted in December 2008 among 16 women; convenience sampled from Dar Es Salaam to ensure 6 current IUCD users, 5 ex-IUCD users, 3 users of other modern methods and 2 non-users. This study used in-depth interview, photo narratives and collages techniques to explore the reasons behind the behaviors and decisions, with the intent in particular of comparing long-term method users (IUCD in this case) with other methods users.

Two levels of quantitative study analysis were done: monitoring: assessing levels and trends of indicators behavior, risk/need, behavioral determinants, and exposure to social marketing activities among women of reproductive age in Tanzania; and segmentation which involves dividing a target heterogeneous population into homogenous groups based on behavior of interest, and then identifying behavioral determinants and population characteristics that are significantly different for behaviors versus non-behaviors. The interested behavior was currently using family planning method.

4. Data

**Abbreviated Family Planning Segmentation Table**

**Women 15-49, not pregnant and not using condoms**

1st number: Currently Using Family Planning (including traditional methods)

2nd number: Currently not Using Family Planning

Means: scale 1-4

Opportunity

Availability 3.06 2.21
CO4: 4

Influence of Independent and Proximate Variables in Predicting Ever-use, Current-use and use of condom during last sex in Nigeria.

Akanni Ibuken Akinyemi, Funmi Banjo, Opeyemi Abiola Fadeyibi, Olusina Bamiwuye, Alfred Adeagbo Adewuyi
Obafemi Awolowo University, Nigeria; akakanni@yahoo.ca

Issues affecting low use of condom in Nigeria
1. Background/Significance: The high prevalence of HIV/AIDS and other sexually transmitted diseases in Nigeria constitute a major public health concern. Also, the estimate of unwanted pregnancies and unsafe abortion in the country presented a very appalling reflection. The contribution of unwanted pregnancies and unsafe abortion to maternal morbidity and mortality in the country is very high (AGI, 2006). Despite these poor health outcomes, the contraceptive prevalence rate (CPR) is still very low in Nigeria (less than 15 percent). Condom use is one of the major forms of family planning that reduces the likelihood of contracting sexually transmitted infections, including HIV/AIDS. It also reduces the risk of unwanted pregnancies and unsafe abortion. Although more than half of the Nigeria adult population expressed the knowledge that condom use is a preventive for HIV/AIDS and unwanted pregnancies (NDHS, 2003; 2008), its use is still very low. The gap identified therefore is to examine the factors associated with the use of condom.

2. Research: State main question/hypothesis: What are the independent and proximate determinants of ever use, current use and use of condom during last sex? Are those involved in high risk sexual behaviour utilizing condom? In what ways can program and policy reduce the obstacles towards effective use of condom?

3. Methodology (including location, setting, period, analysis approach): The article make use of secondary data from USAID-COMPASS midline evaluation survey of year 2007 on basic family planning, reproductive health and Child Health Outcome in five states of the country. The current article focused on 3,797 respondents of reproductive age who were already sexually active. These include 571 from Bauchi, 544 from FCT, 1,011 from Kano, 1,144 from Lagos and 527 from Nassarawa respectively. We examined the influence of the independent and proximate variables through both bivariate (Cross tabulation and Chi-square) and multivariate analysis (Logistic regression models). Three outcome variables were considered (ever-use, current use, use during last sex) and six logistic regression models were simulated to examine (i) influence of selected independent variables on each of the dependent variables, and (ii) the influence of both the independent and proximate variables.

4. Data (if relevant): The data was collected through a multistage sampling technique in year 2007. Eighteen independent and nine proximate variables were simulated in the model.

5. Findings: Ever use of condom was estimated at 14 percent, current use at 8.8 percent and use during the last sex was 11.2. There were variations between the sexes in the proportion reported. Male were more likely to report ever use more than females (odd- 1.3, p=.006), residents of FCT were also more than twice more likely than those in Nassarawa to report ever use. Those in older ages, and those with higher education showed a higher degree of likelihood to report ever use of condom. The proportion of those with multiple sexual partners who reported ever use of condom for fears of STIs and pregnancies, was twice more likely than those who used condom for other reason. The distribution was also similar for current use of condom and condom use during last sex.
Among the 18 independent and 9 proximate variables fielded in the first set of model, 9 of these were statistically significant (p<.05) in predicting ever use of condom (6 independent and 3 proximate variables), 10 were statistically significant (p<.05) in predicting current use (6 independent and 4 proximate variables), and 6 were statistically significant in predicting condom use during last sex (4 independent and 2 proximate variables). The second set of model considered only the 18 independent variables. The model showed that 8 variables out of these were statistically significant in predicting both ever use and current use of condom while 11 variables were statistically significant in predicting condom use during last sex.

6. Research: State knowledge contribution: Individual and proximate factors that may influence and/or hinder the use of condom were presented. The paper raised some fundamental issues in policy/program direction on the determinants of condom use. Program efforts need to focus on the predictors of condom use in order to raise CPR in Nigeria and by this improve family planning and reproductive health indicators in the country. This will go a long way in reducing the prevalence of STIs including HIV/AIDS.

C04: 5

"Social Change to Increase Family Planning Use – Strategies and Impact Documentation"

Marcie Rubardt1, Azrum Ciloglu1, Doris Bartel1, Rob Stephenson2

1CARE USA, United States of America; 2Rollins School of Public Health, Emory University; mrubardt@care.org

Background / Significance

CARE’s recent work in sexual and reproductive health has focused on understanding the role of social factors on family planning uptake and continuation. These social factors include gender and power relations at the household level, as well as social norms around gender and fertility, and capacity to take action at the community level. The Social Analysis and Action (SAA) approach builds on a standard community action cycle with the addition of ongoing exploration, identification and reflection on social barriers to reproductive health, by staff, with the participation of community members. At the core of the SAA approach is the belief that in order for field staff to facilitate such a process with communities, they must first be involved in a personal exploration and self-challenge process, often leading to "personal transformation", since they are often part of social norms they may be seeking to change.

Program Intervention

This paper presents the application of the Social Analysis and Action approach for increasing family planning utilization in Kenya, Ethiopia, and Rwanda. The SAA approach is being implemented through an integration of family planning activities with village savings and loans projects in Ethiopia and Rwanda, and through a Prevention of Mother to Child Transmission project in Kenya. All three country teams initially took several months to explore issues around social and cultural norms with field staff, and afterwards to explore similar issues in the communities identified for participation. The results of this initial exploration were used to develop a model identifying key social factors at the household and community levels that influence family planning behaviors. The three-country program design provides an opportunity to compare differences in strategies and outcomes between the countries.

Methodology

In February 2009, a baseline survey, including a household quantitative survey and a series of qualitative participatory tools, was carried out to measure the current status of gender and social norms as well as family planning behaviors. The qualitative complement to the quantitative survey allows for significant triangulation and deeper understanding of the most important social factors. Data were analyzed separately for men and women in each of the three countries. The final sample size ranged from 292 – 302 men per country and 594 – 646 women per country.

Findings

• Respondents had high rates of approval for couples to use family planning (88 – 100%), but approval for young married couples using family planning drops significantly (20 – 52%) and approval for young unmarried couples using varied widely (10% - Ethiopian women – 90% - Rwandan women).

• When considering respondents’ perception of social norms, there was general agreement that women should not marry until they are eighteen (except Ethiopia) and that they should be educated. However, few thought it was up to the couple to decide when to have their first child (5 – 30%) and about half (43 – 62%) felt community norms still call for having more boys than girls.

• Wanting more children was the most common reason given for not using family planning, (31 – 62%). Only Kenyan men listed opposition as one of their top three reasons (9%) for non-use of family planning.

Seventeen gender attitude questions were combined into a “gender equitable attitudes scale” and five sexual relationship power questions were combined into a “relationship power” scale. Scoring high on either or both of these scales (generally more equitable attitudes and behaviors) tended to be significantly associated with family planning use.

• Ethiopian women and Rwandan men tended to have less gender equitable attitudes with means of 5.6 and 5.7 respectively (out of 17 being a perfect score for gender equity). In both Kenya and Rwanda, the women tended to have less equitable attitudes than the men, while in Rwanda it was the reverse.

High scores on the equity and power scales, as well as education, age at marriage, and mobility are associated with family planning use. Community norms for wanting more boys were associated with individual preference for boy children, as were mobility and equity.

Contribution

This work has two primary contributions to make to the field of family planning: development and documentation of strategies to achieve change in gender and social attitudes around fertility, power, and equity, and documentation of the impact that such changes actually have on family planning use. Further results will be presented to show additional associations such as:

• Social factors associated with desire for small families and son preference
• Social factors associated with higher equity scores on the power and equity scales
• Associations between individual attitudes and community norms.

As this three-country project is in the beginning stages, only the baseline data will be presented. However the authors will explore the potential for tailoring community level activities to address the data findings and inform the design of the country programs in the upcoming three years.

D04: Integrating FP and HIV Programs III

Time: Monday, 16 November 2009: 4:00pm - 5:30pm

D04: 1
Contraception continuation and initiation by newly diagnosed HIV-infected women in Malawi

Gretchen Sauer Stuart1, Rosalie Dominik1, Francis E. A. Martinson1, Kimberly A. Powers1, David A. Chilangozi2, Emmie D. Msiska1, Emma I. Kachipapa1, Chimwemwe D. Mphande2, Rob Stephenson3, Amy O. Tsui1, Mina C. Hesseinipour1–3, Irving Hoffman1

1University of North Carolina Chapel Hill, United States of America; 2University of North Carolina Project, Lilongwe, Malawi; 3Emory University, Atlanta, Georgia, USA; 4Johns Hopkins University, Baltimore, MD, USA; gstuart@med.unc.edu

Background and significance

In Malawi HIV prevalence, unwanted pregnancy rates, and unmet contraceptive needs are among the highest in the world. The objective of this secondary analysis is to estimate the probability of contraception continuation in newly diagnosed HIV+ women, and determining how continuation may differ according to method of contraceptive used at enrollment.

Hypothesis or intervention tested

The overall hypothesis of this secondary data analysis was that newly diagnosed HIV+ women who have access to clinical family planning and contraceptive services at 1-3 month intervals would have a high probability of continuing the contraceptive method they were on immediately after receiving their HIV+ diagnosis.

Methodology

The study is a secondary data analysis of prospective cohort study conducted at three clinical sites in Lilongwe, Malawi from December 2003 through January 2005. The Institutional Review Boards in Malawi and at the University of North Carolina at Chapel Hill approved the original protocol and consent forms.

Descriptive statistics and frequencies were used to describe the groups of contraceptive users to non-users. Kaplan-Meier estimates were used to estimate contraception continuation and initiation rates. The method discontinuation date was imputed as the mid-point between the first visit date where the woman reported not using the method she had been using at enrollment and her previous visit date. The probability of method initiation for women not using a contraceptive method at enrollment was estimated to be one minus the KM estimate of the probability of remaining a nonuser. For the method initiation analysis, the date of the first post-enrollment visit where the woman reported use of any contraceptive method was considered the initiation date. Women who did not initiate use any time after enrollment were censored as of their last visit date.

Data

119 (52%) of the 227 newly diagnosed HIV+ women enrolled used contraception at enrollment; 84 (37%) injectable, 15 (7%) oral contraceptives (OCPs), 14 (6%) condoms, 4 (2%) implants, and 2 (1%) unspecified. 108 women reported using no contraception method; 38 (35%) stated an intent to use a method in the future and 69 (64%) stated they had no intent to use contraceptives in the future, and one woman did not state her intent at all.

Findings

The probability of continuing any contraceptive if using any contraceptive at enrollment was 0.41 (95% CI 0.22, 0.59). Injectable users had a 0.61 (95% CI 0.50, 0.71) probability of continuing injectables, however no women using OCPs at enrollment continued using contraception through 12 months. Stratifying according to the site of enrollment, women enrolled from the family planning clinic had a probability of continuing contraception through the 12-month study period of 0.44 (95% CI 0.21, 0.65), compared to 0.37 (95% CI 0.14, 0.61) and 0.26 (95% CI 0.5, 0.55) at the voluntary counseling and testing center and the sexually transmitted infection clinic, respectively.

Women who stated they intended to start a method had a higher probability of actually starting contraceptives than the group who stated they did not intend to start a method; 0.68 (95% CI 0.44, 0.89) compared to 0.30 (95% CI 0.20, 0.43). Women enrolled from the family planning clinic had 0.78 (95% CI 0.49, 0.97) probability of initiating a contraceptive method, compared to 0.38 (95% CI 0.21, 0.62) at the voluntary counseling and testing clinic, and 0.49 (95% CI 0.33, 0.69) at the sexually transmitted infection clinic.

Knowledge contribution or lessons learned

Despite access to family planning services the overall probability of newly diagnosed HIV+ women in Lilongwe, Malawi continuing any contraceptive was less than 0.5. Interventions designed to improve contraception continuation and to meet the needs of women who state an intention to start contraception are needed.

Many women who stated an intent to initiate contraception did, however the probability was greater among women seen at the family planning clinic initially than women seen at the voluntary counseling and testing center; ensuring availability of contraceptives so all women who state intent to use contraceptives can obtain them immediately would be a beneficial intervention achieved when HIV care and family planning care are integrated into one clinical setting. The similarities between follow-up for family planning services and follow-up for HIV care deserve attention. For instance, HIV+ women need care at regular intervals to monitor their CD4 counts so they can start antiretrovirals immediately upon indication. Similarly, women need regular follow-up for contraceptives to receive counseling of side effects or a refill of the method such as injectables or oral contraceptives. Integrating family planning services with HIV care is a global health priority and deserves funds and leadership to ensure the health of women and their families.

DO4: 2

Improving integration of family planning into ART services: Experiences from development of a provider orientation module

Jane Alai1, Solomon Marsden2, Tom Marwa2, Sharon Tsui1, Violet Ambundo1, Dickson Mwakagalu1, Mary Gathitu2, Margaret Gitau2

1Family Health International, Kenya; 2JHPIEGO; 3Family Health International, USA; 4USAID-AIDS Population Health Integrated Assistance (USAID APHIA II) – Rift Valley; 5USAID APHIA II Coast; 6Division of Reproductive Health (DRH) – Ministry of Public Health and Sanitation; 7National AIDS and STIs Coordinating Programme (NASCOP) – Ministry of Medical Services/Ministry of Public Health and Sanitation; Jalai@fhi.org

Background/Significance

Increasingly, the need to provide Family Planning (FP) through antiretroviral therapy (ART) treatment centres is recognized. In Kenya, there is an initiative to integrate FP services in HIV Care and Treatment (HIV-CT) services. This paper discusses the process and experiences from the development of a module to train HIV-CT providers in the provision of FP services to their clients.

Program Activity

Development of an FP-HIV integration orientation package (OP) for HIV care and treatment (HIV-CT) service providers following evidence of unmet need for FP among women on ART.

Methodology
Formative research was conducted in 2007 to understand fertility intentions of HIV-infected clients at a Provincial General Hospital HIV-CT centre. The study participants included female clients attending the service, and health providers. Research findings were disseminated in mid 2008 at a National stakeholders’ meeting. Subsequently, a task force of RH-HIV integration stakeholders including the Ministries of Health (Reproductive Health [RH] and HIV divisions), local and international NGOs working in RH and HIV, and development, was put together to develop a provider orientation package. A draft RH-HIV orientation package developed by Ipiiego, relevant prevention with positives (PwP) materials developed and field tested by CDC, the FHI FP-HIV Toolkit for increasing access to contraception for clients with HIV, and a National Integrated Training Manual for VCT providers, among others, were reviewed and harmonized into one comprehensive draft FP-HIV integration orientation package (OP). A 3-days workshop was held in Nairobi in October 2008 to field-test the draft package and orient Ministry of Health Trainers-of-Trainers (ToTs) selected from all eight provinces of Kenya. Between November 2008 and January 2009 some members of the taskforce oriented and field tested the revised draft FP-HIV integration OP among public service providers (n=89) in Coast and Rift Valley provinces. Field test experiences were shared with the task force and the National RH-HIV integration committee at a meeting in March 2009 for further improvement of the draft OP. The revised draft OP was then informally cleared for use in orientation of more providers as it underwent further review by DRH and NASCOP. This was in recognition of the fact HIV-CT service providers were increasingly facing a challenge with unintended pregnancies among HIV-CT clients and needed guidance discussing and/or providing FP to HIV-infected couples. Concurrently with the process of development the OP, a collaborative team of FHI and USAID APHIA II Coast and Rift Valley developed indicators to capture and measure RH-HIV integration. These indicators were shared with the National RH-HIV integration committee in November 2008. A sub-committee with representation from NASCOP, DRH, WHO, Pathfinder, Population Council and MSH was formed to refine the indicators for inclusion in the National RH-HIV integration strategy which is also at advanced stages of development and expected to be officially launched together with the RH-HIV orientation package.

Findings

USAID APHIA II programs monitoring and evaluation systems indicate FP-HIV integration has started in public HIV-CT services, albeit at different levels depending on capacity at health facility type/level. For instance, HIV-CT services at the provincial level and selected district level facilities are able to provide comprehensive FP services including screening for fertility intentions of clients, FP counseling, provision of FP methods including condoms, pills, implants, and injectables. These are all provided within the HIV-CT centre, though by different health providers (in different rooms) – referred to as a “one shop stop” service. Clients are referred to the FP clinic for surgical methods (if needed) within the same hospital. On the other hand, an HIV-CT at the health centre and dispensary levels is more likely to provide a “one stop shop” service – the same provider offers services including screening for fertility intentions, FP counseling and/or methods including condoms, pills, and injectables. Often, HIV-infected clients at this level are referred to the nearest government hospital (District or Provincial) for surgical methods. A monitoring activity conducted in May 2009 by FHI and NASCOP/DRH officers suggests an immediate challenge exists in record keeping and documentation of provision of FP services in the HIV-CT.

Lessons learned

The experience of development of the package reiterates the fact that introduction of an innovation takes time. The Ministries of Health remain a critical partner, not just as the end users of research and program output, but also for bringing partners together to ensure best results and effective use of technical expertise and financial resources contributed by different collaborating agencies. Monitoring and continued operations research is key to ensuring services are provided and strengths, weaknesses, opportunities, and threats are identified for continual improvement of integration.

DO4: 3

Integrating HIV and Family Planning Services: Are Providers Ready?

Susan Patricia Ena Adamchak1, Barbara Janowicz1, Jennifer Liku2, Emmanuel Munyambanza3, Thomas Grey1, Rick Homan1, Emily Keyes1

1Family Health International, United States of America; 2Family Health International, Nairobi, Kenya; 3Family Health International, Kigali, Rwanda; sadamchak@fhi.org

Background / Significance

There is growing global interest in the integration of HIV and family planning services. In 2007-2008, an assessment of three models of integrated services (family planning in care and treatment services, family planning in counselling and testing, and HIV services, mainly counselling and testing, in family planning) was carried out in five countries: Ethiopia, Kenya, Rwanda, South Africa and Uganda. The goal of the assessment was to provide international donors and local programs with information needed to improve integrated services so as to maximize impact and optimize the potential for scale up.

Hypothesis or Intervention / Activity Tested

One objective of the assessment was to determine the preparedness of clinics and service providers to meet demand for integrated family planning and HIV services. Two elements were considered: the performance of the original base service, and the provider knowledge and attitudes regarding the newly integrated service.

Methodology

Following a desk review and field survey to identify programs that offered integrated services, 20 programs representing both the public and private sectors that offered at least one of the integrated models noted above were purposively selected to participate in the study. During visits to 102 clinics in the five countries, data were collected from 180 Providers and 111 managers interviewed using structured questionnaires. A structured observation was also carried out at each clinic, identifying key infrastructure elements such as the availability of promotional and behavior change communication materials and provider time use. The assessment protocol was approved by institutional review boards within each country as well as by the sponsoring organization, and informed consent was obtained from all participants.

Data

Data were analyzed using a case study approach, with each integration model representing a case. Analysis largely consists of bivariate statistics and summary measures including percentages, means and medians. Data were entered in each country using either EPI-Info DOS version 6.04d or EPI-Info for Windows version 3.2.2. Data were verified and analyzed using SAS version 9.1 and STATA version 9.2.

Findings

Most services had only one or two providers on duty; many were not trained to offer integrated services. Stock outs of contraceptives and HIV test kits had occurred in each country in the prior six months in all services, though generally they were not extensive. No more than two-thirds of the HIV services had posters displayed to promote their base service, and far fewer had posters about FP services. Family planning providers were more likely than their HIV counterparts to have been trained in the integrated service; fewer than half the CT counselors in three countries had received cross-training in family planning counseling or service delivery. Many providers lacked simple job aids, including samples of FP methods, flip charts and check lists to guide counseling sessions.
Though many providers met weekly with supervisors, few reported receiving help from their supervisors in offering integrated services. Many providers incorrectly believed contraceptive pills or IUDs were not suitable methods for HIV+ women. With only two exceptions, fewer than half the providers in any service spoke with clients about the integrated service on the day of interview. Clients were infrequently screened for their fertility intentions and their unmet need for contraception, or for HIV testing among those attending family planning services.

Lessons Learned

The base services in these five countries in many ways remain fragile, and providers are being asked to introduce new services with only limited training and resources. The base service must be made strong enough to absorb the integrated service by allocating resources for training, materials, infrastructure and supervisory support. Providers should be supported to offer integrated services with job aids and supervision. Systematic in-service training is needed to ensure providers are knowledgeable in key concepts related to their original service and the integrated service, particularly the WHO medical eligibility criteria for contraceptive methods appropriate for HIV-positive women. New tools and training that take into account changing knowledge about the HIV/AIDS epidemic, the safety and efficacy of contraceptive use among HIV-positive women, client profiles, and availability of complementary family planning and treatment services are also needed.

D04: 4

Providing family planning in Ethiopian voluntary HIV counseling and testing facilities: Client, counselor and facility-level considerations.

Heather Bradley1, Duff Gillespie1, Aklilu Kidanu2, Yung-Ting Bonnenfant1, Sabrina Karklin1

1Johns Hopkins Bloomberg School of Public Health, United States of America; 2Miz-Hasab Research Center, Ethiopia; hbradley@jhsph.edu

Background: Governments and donors encourage the integration of family planning into voluntary HIV counseling and testing services, yet very little is known about operationalizing integrated services.

Hypothesis or Intervention/Activity Tested: We aimed to determine whether VCT counselors working in public sector facilities in Oromia Region, Ethiopia, could feasibly offer family planning and what kinds of clients would use such services.

Methodology: In 2006, we interviewed 4,000 VCT clients receiving standard of care VCT services in 8 Ethiopian public sector facilities about their sexual behavior, as well as their contraceptive knowledge, attitudes and use. We then introduced family planning services in these VCT facilities. The family planning intervention included developing family planning messages for VCT clients, training VCT counselors in family planning, ensuring contraceptive supplies in VCT counseling rooms and monitoring services. Approximately 18 months after implementation of this intervention, we interviewed 4,000 additional clients attending the same facilities.

During the inter-survey period, VCT counselors in the study facilities were interviewed about their socio-demographic characteristics, family planning knowledge, and attitudes towards work. These interviews were conducted before and after their training in family planning. Information on facility characteristics, such as number of counseling rooms, was collected from facility supervisors at the time of both surveys. Counselor and facility information was linked to client data from before- and after-family planning surveys.

Gender-stratified, multilevel models, including client, provider and facility-level variables, were constructed to assess three outcomes: whether clients received contraceptive counseling, whether clients obtained contraceptive methods during VCT, and whether clients intended to use contraceptives consistently post-VCT. Each model included provider- and facility-level random intercepts to account for clustering of observations within providers and facilities.

Data: Clients were excluded from the regression analyses if their VCT provider was not interviewed, but sensitivity analyses showed that these clients were not significantly different from those included in the models. All clients from one VCT facility were also excluded because the facility did not successfully implement the intervention. The sample size used for the present analysis was 2,379 pre-intervention and 3,374 post-intervention clients.

Regression analysis of the first two outcomes, receipt of contraceptive counseling and obtaining a contraceptive method, was limited to those attending VCT post-intervention. Pre-intervention study participants were not included since family planning services in VCT were essentially non-existent at that time. For the consistent condom use outcome, clients from both pre- and post-intervention samples were used. However, we excluded individuals who intended to be abstinent for at least the next two months.

Findings: Study clients demonstrated lower than expected immediate need for contraception. In the post-intervention survey, only 29% of women and 22% of men had been sexually active in the past 30 days, and 74% of the sexually active women were already using contraceptives.

Despite the relatively low risk this population had for unwanted pregnancy, family planning counseling in VCT increased significantly, from 2% to 41% for women and from 3% to 29% for men. In the multi-level analysis, men and women were 3.4 and 2.5 times more likely to accept contraceptive methods. Men attending facilities with smaller client loads and more counseling rooms were also much more likely to receive contraceptive counseling and methods. Counselors’ perception of the adequacy of contraceptive supplies was highly associated with their clients’ contraceptive uptake and intentions. After family planning services were introduced, women were no more likely to intend to use condoms in the future, but men were twice as likely to intend to use condoms consistently.

Knowledge Contribution or Lessons Learned: Integrating VCT and family planning services is likely to be an effective programmatic option. Clients at higher risk for HIV or unintended pregnancy are more likely to use integrated services and should be targeted.

D04: 5

The Effect of VCT Acceptance and Uptake of Antiretroviral Treatment on Modern Contraceptive Use Among Women in Rakai, Uganda

Fredrick E Makumbi, Gertrude F Nakigozi, Tom Lutalo, Joseph Kagayi, Joseph Sekasanvu, Absalom Settuba, David Serwada, Maria Wawer, Ron Gray

Makerere University School of Public Health, Uganda; fmakumbi@yahoo.com
1. Background/Significance Integration of family planning into Voluntary Counseling and Testing (VCT), and Antiretroviral Treatment (ART) programs has been advanced as a strategy to increase uptake of modern contraceptive (MCP) in resource limited settings.

2. Research: State main question/hypothesis To compare the rate of MCP and condoms for family planning (CFP) between VCT and ART recipients among women aged 15-49 years in Rakai, Uganda

Program: State intervention/activity tested

3. Methodology (including location, setting, period, analysis approach) Annual household surveys were conducted in a community cohort in Rakai District, Uganda since 1994/95. Interviews were conducted for consenting adults aged 15-49 years who also provided blood for HIV testing, and received HIV-1 results and post-test counseling on request from trained community based counselors, who referred all HIV+ respondents for care including antiretroviral therapy when eligible, at the Rakai health Sciences program's (RHSP) HIV care and ART clinics. Data for this analysis are drawn from a survey conducted 2007/8, where receipt of HIV test results in the past 12 months were obtained from questionnaire information or HIV counseling records. All non-pregnant women were categorized by VCT receipt, HIV and ART status. Use of modern Family Planning was categorized into -None, condoms-only (CFP) or “Modern methods” (pills, injections, IUD, and Norplant). In this cross-sectional analysis, we used multinomial logistic regression to estimate relative risk ratios (RRR) of use versus non-use of contraception, with their 95% confidence intervals (CI), adjusting for age, HIV status, desired number of lifetime children, and stratified by marital union status

4. Data (If relevant)

Findings A total of 3528 non-pregnant women in a marital union and 1900 unmarried were interviewed, with about 50% receipt of VCT in each group, and 29.5% (238/816) of HIV+ already initiated on ART. For women in marital union, receipt of VCT, adj.RRR=1.66; CI (1.30, 2.13) and HIV+ status, adj.RRR=3.53; CI (2.63, 4.74), and being on ART adj.RRR=2.90; CI (1.63, 5.14) were significantly associated with higher rates of condom use for family planning. However, VCT, HIV status or ART were not associated with “modern methods”. For unmarried women, HIV+ status, was associated with condom use adj.RRR=1.53; CI (1.14, 2.06), and with use of “modern methods”, HIV+ status, adj.RRR=1.45; CI (1.04, 2.01). A higher desired number of lifetime children (6+) was a strong predictor of non-use of “modern methods” or condoms for family planning.

5. Research: State knowledge contribution Condom use for family planning was significantly higher among married women who received VCT and those on ART, but use of “modern methods” did not differ by VCT or ART status. Among unmarried women, HIV+ status was associated with higher rate of condom and “modern methods”.

6. Program: State lessons learned

**E04: Hormonal Contraception and HIV**

**Time:** Monday, 16 November 2009: 4:00pm - 5:30pm

**E04: 1 Hormonal Contraception and HIV-1 Infectivity: an Overview**

Ludo Lavreys, Jared Baeten
University of Washington; cmorrison@fhi.org

**Background**

One hundred fifty million women worldwide use hormonal forms of contraception, many of whom live in areas of high HIV-1 prevalence. Women account for half of all HIV-1 infections worldwide and 60% of cases in sub-Saharan Africa, the region hardest hit by the global epidemic. Safe and effective family planning options are essential for women with HIV-1. Laboratory studies have documented systemic and mucosal immunologic and cellular changes associated with hormonal contraceptive use. The question whether the use of hormonal contraceptive by women who are infected with HIV-1 increases HIV-1 infectiousness and risk of transmission to sexual partners is an issue of public health importance. However, only a limited number of studies have addressed this question and the results have been inconsistent.

**Summary of available data**

Studies directly measuring the effect of hormonal contraception on HIV-1 transmission to sexual partners have been difficult to conduct. Instead, most studies of the effect of hormonal contraception on HIV-1 infectivity have relied on genital shedding of HIV-1 as a proxy measure of infectiousness. Such studies have suggested direct and indirect mechanisms by which hormonal contraception might increase HIV-1 infectivity.

**Direct effects**

Studies of HIV-1 shedding during the menstrual cycle have demonstrated that HIV-1 RNA reaches its highest levels in genital secretions during the luteal phase, when progesterone predominates. This provides biologic plausibility for the hypothesis of a relationship between female hormone levels and HIV-1 infectiousness.

Two cross-sectional studies from Mombasa, Kenya found strong associations between hormonal contraceptive use and genital shedding of HIV-1 DNA (i.e., cell-associated virus). However, in two studies from the U.S., no association between contraceptive use and shedding of HIV-1 RNA (i.e., free virus) was seen. A prospective study, conducted among women attending a family planning clinic in Mombasa, found a modest but statistically significant increase in detection of cervical HIV-1 DNA two months after initiating hormonal contraception but no change in genital HIV-1 RNA.

More recently, two studies from Africa (Uganda/Zimbabwe and Kenya) examined the relationship between hormonal contraceptive use and HIV-1 RNA shedding during primary HIV-1 infection. Both found that genital HIV-1 levels were high, as would be expected, but neither found an association between hormonal contraception and genital HIV-1 shedding.

**Indirect effects**

Observational studies, many from the 1980s and early 1990s, found that hormonal contraception increases a woman’s risk for acquiring some sexually transmitted infections, particularly infection with Chlamydia trachomatis. Genital tract infections are well-known to increase genital HIV-1 shedding, and thus it has been hypothesized that hormonal contraception may increase HIV-1 infectivity indirectly by increasing susceptibility to sexually transmitted infections. Recent studies from the U.S. and Kenya reported increased risk for cervical inflammation among women using progesterone-based contraception and an increased risk for C. trachomatis and non-specific cervicitis.
Particular attention has been focused on the relationship between hormonal contraception and herpetic simplex virus type 2 (HSV-2) reactivation, given the strong relationship between HSV-2 and HIV-1 acquisition and transmission seen in observational studies. Genital shedding of HIV-1 is increased when HSV-2 reactivates. Data examining the relationship between hormonal contraception with increased HSV-2 reactivation has been inconsistent.

Research priorities

Longitudinal studies of genital HIV-1 shedding as a surrogate marker of HIV-1 infectiousness should be conducted, with measurement at multiple time points after contraceptive initiation. These studies ideally would include quantitative analyses of both cell-free and cell-associated HIV-1, as it is unclear which is the best marker for infectivity. Studies of contraceptive use and genital HIV-1 shedding among women taking antiretroviral therapy should be a priority. Finally, studies measuring the relationship between hormonal contraceptive use and female-to-male HIV-1 transmission risk – such as observational studies among HIV-1 serodiscordant couples – would offer the best opportunity to directly measure the true effects of contraceptive use on HIV-1 infectiousness.

EO4: 2

An Overview of hormonal contraception and HIV disease progression

Elizabeth M Stringer
University of Alabama at Birmingham; cmorrison@fhi.org

Background: There are almost 15 million women infected with HIV worldwide. HIV-infected women need access to safe and effective contraception, just as uninfected women do. Recent animal and human data suggest that hormonal contraception may affect HIV disease progression.

Animal Data: In 1996 Marx studied the effect of progesterone implants on Simian Immunodeficiency Virus (SIV). He found that macaques implanted with 200mg of subcutaneous progesterone 90 days prior to infection with SIVmac were more likely to become infected than were controls. Infected animals exposed to progesterone also had higher plasma viral loads for the first three months after infection. Trunova et al studied the impact of Depo Provera (DMPA) on macaques coinfected with X4-SIV and R5-SIV on viral load, virus complexity, and the genotype of circulating viruses. Nine macaques received DMPA and varying concentrations of SHIV and 3 macaques received only SHIV. Macaques implanted with DMPA were more likely to acquire multiple viral variants of SHIV, have earlier R5 dominance, and a delayed cellular immune response.

Clinical data: One of the first human studies to report on the possible effect of hormonal contraception on HIV disease progression was the Mombasa cohort of Kenyan sex workers. In this study, women using DMPA at the time of HIV acquisition had an almost two fold higher viral set point (+0.33 log 10 copies/ml, p=0.03). 89/156 (57%) women who used hormonal contraception at the time of HIV acquisition acquired multiple HIV viral variants and multiple viral variants were more common in women with hormonal contraceptive use (OR 2.7; p=0.003). Women who acquired multiple viral genotypes had higher viral loads 4-24 months after infection (4.84 vs. 4.64 log 10 copies/ml; p=0.04) as well as lower CD4 counts (median 416 vs. 617 cells/μl, p=0.01) and a faster decline in their CD4+ counts over time.

Between June 2002 and July 2003, our group in Lusaka enrolled 599 HIV infected postpartum women into a randomized trial of the copper IUD versus hormonal contraception (women chose between DMPA and combined oral contraceptive pills (OCPs). Although HIV disease progression was not an a priori hypothesis (It was a safety study), we observed that women randomized to receive hormonal contraception were more likely to experience the composite outcome of death or CD4+ count decline below 200 cells/μl (Hazard ratio [HR]: 1.6; 95% CI 1.1 - 2.3). In a secondary analysis, we examined the individual impact of OCP and DMPA exposure on HIV disease progression. We categorized contraceptive exposure in two ways: by initial dispensation, the intent-to-treat analysis and as an actual-use analysis in which the contraceptive method is treated as a time-varying exposure. 175/595 women met the criteria of the composite outcome of HIV disease progression. Compared to the IUD group, the crude hazard ratios from the intent-to-treat Cox analysis for the composite outcome in the DMPA group and OCP group were 1.77 (95%CI, 1.27-2.47) and 1.51 (95%CI, 1.00-2.30). Treating the contraception exposure as a time-varying exposure, the hazard ratios for DMPA and OCPs were 1.47 (95%CI, 1.05-2.06) and 1.53 (95%CI, 1.02-2.31), respectively, suggesting faster HIV disease progression among women who used hormonal contraception.

Three other studies do not suggest an effect of hormonal contraception on HIV disease progression. In a sub-analysis of the Women’s Interagency Health Study, women using hormonal contraception had a small increase in CD4+ cell counts and no change in viral load over time. Richardson and colleagues conducted a prospective cohort study of recently post-partum women in Kenya to characterize determinates of disease progression. They found no significant changes in viral load or CD4+ count that could be attributed to contraceptive exposure. Finally, the incidence of HIV disease progression among antiretroviral therapy (ART)-naive women with and without exposure to hormonal contraception in the "MTCT Plus" cohort is reviewed. In this analysis disease progression was defined as: 1) becoming eligible for/starting ART or 2) death. At baseline, 3,064 women (75%) reported using no contraception/non-hormonal contraception, compared to 1,045 (25%) who reported hormonal contraceptive use: 823 (79%) implants/injectables contraception and 222/1,045 (21%) OCPs. Neither implants/injectables [Adjusted Hazard Ratio (AHR) 1.0; 95% CI: 0.8-1.1] nor OCPs [AHR 0.8; 95% CI: 0.6-1.1] were associated with our primary outcome of HIV disease progression: becoming eligible for/starting ART, or death. Treating contraceptive exposure as a time-varying covariate did not change the findings.

Possible biological explanations for the results of the data presented will also be discussed.

Conclusions: Existing studies are in conflict on the impact of hormonal contraception on HIV disease progression. Ensuring safe, woman-controlled contraceptive access to HIV-infected women who wish to delay or forgo childbearing is critical. Further investigation into the effect of hormonal contraception on HIV-1 disease progression is a matter of particular urgency.

EO4: 3

Hormonal Contraception and HIV Acquisition

Charlie Morrison
Family Health International, United States of America; cmorison@fhi.org

Background: Hormonal contraception (HC) 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). Injectable progestin use (DMPA and norethisterone enantheate (Net-En)) is increasing especially among young women and women in Southern Africa where HIV and STI incidence is high. Condom use remains low within marriage and among women using highly effective contraception.

Objective: 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.

Methodology: We will summarize and present data from all published prospective studies of hormonal contraceptive use and HIV acquisition. We will stratify the analysis based on general and high-risk populations of women. We will also summarize data on particular subgroups of interest including young women (<
25 years) and HSV-2 negative women. New results will be presented from an analysis of the HC and HIV acquisition relationship from the Carraguard Microbicide Trial dataset.

Results:

Research conducted among macaques suggests that use of progesterin-only contraception, in particular DMPA, increases the risk of simian immunodeficiency virus (SIV) acquisition. In addition, levels of post-infection viremia are higher in DMPA-treated macaques than in DMPA-naive macaques. Conversely, macaques treated with estrogen appear to be protected against vaginal SIV transmission. This suggests that the hypoestrogenic effect associated with DMPA use may be responsible for the increase in SIV acquisition.

Evidence on whether hormonal contraceptive methods alter a woman's risk of HIV acquisition is mixed. Two of the 13 published prospective studies examining COC use and HIV acquisition found a significantly increased risk of HIV associated with COC use, while 11 studies have not. Of the 11 studies with non-significant results, three report estimates of effect for COC use on HIV acquisition of at least 1.8 (trend towards harmful), while two others report estimates for COC use of 0.5 or lower (trend towards protective). Two major reviews conducted during the 1990s (therefore not including recent studies) reached opposite conclusions on the effect of COC use on risk of HIV acquisition.

Ten prospective studies have examined the relationship between DMPA and HIV acquisition. Three found a significantly increased risk of HIV associated with DMPA, while one reported a raised, but non-significant, relative risk. Two studies reported non-significant protective effects for DMPA on HIV risk (effect estimates of 0.5 or lower). Two recent prospective studies from South Africa reported on the association between the two-monthly injectable progestin Net-en and HIV risk. Neither found a statistically significant effect.

The Hormonal Contraception and Risk of HIV Acquisition (HC-HIV) Study, the largest study conducted among women from a general population group, found important modification of the HC-HIV relationship by age (p<0.001). Among young women (ages 18-24 years), COC (HR=1.59, 95% CI 1.00-2.55) and DMPA (HR=2.36, 95% CI 1.50-3.69) users had an increased risk of HIV acquisition compared to women not using hormonal contraception. However for older women (>25 years) COC (HR=0.50, 95% CI 0.29-0.88) and DMPA (HR=0.47; 95% CI 0.17-0.83) users had a reduced HIV acquisition risk. A similar interaction effect was found in a study of injectable contraception and HIV acquisition conducted in South Africa (Palesa Study). For women 15-19 years, 20-24 years, 25-29 years and 30-34 years (compared with women >35 years), the unadjusted rate ratios were 3.0 (95% CI 0.3-36), 1.9 (95% CI 0.4-11.9), 0.7 (95% CI 0.1-1.9) and 0 (95% CI 0.0-1.4), respectively. However, no difference in the HC-HIV relationship was noted between younger (18-24 years) and older (>25 years) women in the Mombasa Sex Worker Study.

We recently examined the HC and HIV acquisition relationship using data from the Carraguard Microbicide trial. HIV incidence was 2.9, 4.6, 3.5 and 3.2 per 100 wks in the COC, DMPA, Net-En and non-hormonal groups, respectively (p=0.04). However, adjusted hazard ratios (HR) were 0.76 (95% CI 0.46-1.25), 1.21 (95% CI 0.88-1.65) and 0.83 (95% CI 0.57-1.21) among COC, DMPA and Net-En users, respectively compared with the non-hormonal group. Age modified the effect of hormonal contraception on HIV acquisition risk; among young women (<25 years) the adjusted HR were 0.94 (95% CI 0.42-2.07) for COCs, 1.54 (95% CI 0.90-2.61; p=0.11) for DMPA and 1.19 (95% CI 0.69-2.05) for Net-En users.

Conclusions: Among women from the general population, COC and DMPA use does not appear to significantly increase HIV acquisition risk; evidence from studies conducted among high-risk groups of women is more mixed. However, there is some evidence that hormonal contraception, especially DMPA, may increase HIV risk among young women (<25 years). Additional research is urgently needed to understand the effect of hormonal contraceptive use on HIV risk among young women.

F04: 4

Family planning for the prevention of vertical HIV transmission in Uganda

Wolfgang Hadlisch1, John Stover2, Godfrey Esiri3, Malayah Harper4, Jordan Tapper3

1CDC, Uganda; 2Futures Institute, Glastonbury, Connecticut, USA; 3AIDS Control Programme, Ministry of Health, Kampala, Uganda; 4UNAIDS, Kampala, Uganda;

wh3ug@ug.cdc.gov

Background: Uganda has one of the highest total fertility rates (TFR) worldwide. We compared the effects of antiretroviral (ARV) prophylaxis for the prevention of mother-to-child HIV transmission (PMTCT) to that of existing family planning (FP) use and estimated the burden of pediatric HIV disease due to unwanted fertility.

Methodology: Using the demographic software Spectrum, a baseline mathematical projection to estimate the current pediatric HIV burden in Uganda was compared to three hypothetical projections: 1) without ARV-PMTCT (to estimate the effect of ARV-PMTCT), 2) without contraception (effect of existing FP use), 3) without unwanted fertility (effect of unmet FP needs). Key input parameters included HIV prevalence (6.4%), ARV-PMTCT uptake (2007: 33%, 2012: 57%), MTCT probabilities, and TFR (2007: 6.7, 2012: 6.5).

Principal Findings: We estimate that in 2007, an estimated 25,000 vertical infections and 17,000 pediatric AIDS deaths occurred (baseline projection). Existing ARV-PMTCT likely averted 8.1% of infections and 8.5% of deaths. FP use likely averted 19.7% of infections and 13.1% of deaths. Unwanted fertility accounted for 21.3% of infections and 13.4% of deaths. During 2008-2012, an estimated 131,000 vertical infections and 71,000 pediatric AIDS deaths will occur. The projected scale up of ARV-PMTCT (from 39%-57%) may avert 18.1% of infections and 24.5% of deaths. Projected FP use may avert 21.6% of infections and 18.5% of deaths. Unwanted fertility will account for 24.5% of infections and 19.8% of deaths.

Conclusions: Existing FP use contributes as much or more than ARV-PMTCT in mitigating pediatric HIV infection in Uganda. Expanding FP services can substantially contribute towards PMTCT.

F04: Effectiveness of Community-based Distribution

Time: Monday, 16 November 2009: 4:00pm - 5:30pm

F04: 1

Improving family planning utilization by repositioning family planning/ reproductive health program through strengthening community based Health Service Extension Program (HSEP) in Ethiopia.

Dereje Ayele1, Biniyam Ayele1, Yemisirach Belaneh2

1Ethiopian Public Health Association, Ethiopia; 2Packard Foundation Country Advisor; derejeayele@yahoo.com

Background: Low family planning coverage along with high unmet need in Ethiopia has aggravated the health burden in particular to children and mothers. As a major strategy, the Health Service Extension Program was launched in the country to improve access and equity to preventive essential health interventions by
targeting households, particularly women and children. The Health Extension Programme is designed to give services at Kebele/village level covering sixteen health extension packages categorized under three major areas, reproductive health/family planning being as one of the major focus area, and one cross cutting approach. However, its success in the past has often been modest due to several reasons including meager resources, inadequate knowledge and skills of Health Extension Workers, and poor integration of services at the grass root level.

Objectives: This project was a collaborative endeavor by Ministry of Health, Ethiopian Public Health Association, and Packard Foundation to strengthen family planning program by improving performance of Health Extension Workers on reproductive health/family planning through training, supportive supervision, and dissemination of best practices.

Methods: Initially, base line assessment with quantitative and qualitative methods was conducted in 2006 to estimate the level of basic reproductive health indicators and assess the knowledge and working conditions of Health Extension Workers on Reproductive Health issues before the introduction of the project “Repositioning FP/RH services in Ethiopia” in North and South Wollo Zones. Inadequate knowledge and skill of HEWs on family planning was one of the major findings of the study. Based on the gaps identified from the baseline assessment, a total of 1516 (96.8%) HEWs were trained on FP/RH issues supported by practical attachment, following a Training of Trainers offered for 30 health professionals selected from the two zones. Health Extension Program coordinators were trained on Supervision, Monitoring, and Evaluation so as to strengthen the system. And these activities were reinforced by RH/FP Leadership skills training and RH program management for Zonal and Woreda health managers. To provide continuous information and share best practices, a quarterly Health Extension Newsletter is being distributed and in use by all HEWs nationwide. Organizations working on parallel issues in the project areas were identified and a robust network established.

Results: Health Extension Workers obtained hands on knowledge and gained new skills on family planning service provision which they didn’t apprehend in the pre-service training. This is revealed by the significant improvement of clients demand for long term contraceptive methods and referral linkages, as observed during supportive supervision. Organizations working on parallel issues started sharing of resources and minimized duplication of efforts. Joint supportive supervision with the local health authorities became effective and gaps were identified vigorously. The Health Extension Newsletter is owned by the Ministry and demand is created by users.

Conclusions: This is an innovative collaborative model for improving family planning utilization through strengthening Health Service Extension Program. A lesson learned was the value of a collaborative model for revitalizing health extension workers knowledge and skills in order to amplify family planning coverage. Supportive supervision and the system created for involving each actors working at the community level is also worth mentioning. End line assessment will be conducted before replication of the practice by December, 2009. To realize the desired effects of a program, supportive supervision as a keystone in the implementation process is recommended.

F04: 2
What works in family planning interventions: A systematic review of the evidence
Lisa M. Basalla1, Ilene Speizer2, Anna Schurmann3, Farial Fikree4, Gwen Morgan5
1University of North Carolina, United States of America; 2Population Reference Bureau, United States of America; 3African Population & Health Research Center, Kenya; basalla@email.unc.edu

BACKGROUND: Family planning programs have been recognized as cost-effective interventions that lead to positive benefits for individual women and children as well as for national and the environment. Evaluations of family planning programs have demonstrated impacts on increasing contraceptive practice, lowering fertility, and improving maternal and child health outcomes. However, there is a need to update the evidence base about what works in the post-Cairo social, political, and economic context. For this reason, a systematic review of outcome and impact evaluations is vital to identify what is working in family planning programming to support evidence-based decision-making for program design, scale-up, and policy making.

INTERVENTION TESTED: To undertake a systematic review of family planning interventions which were published between 1995 and 2009. Studies included are those that used an experimental or quasi-experimental design or had another way to attribute program inputs to observed changes in fertility or family planning outcomes at the individual or population level.

METHODOLOGY: We systematically searched four electronic databases (MEDLINE, Google Scholar, EconLit, and POPLINE) on evaluations of family planning and reproductive health (FP/RH) programs in developing countries. In addition, we requested copies of working papers and reports on the same topic from individuals and organizations working in the field of FP/RH. Articles were included if they were published between 1995 and 2009, provided information about the interventions, clearly described the aims, and used a quasi-experimental or experimental design or had another method to attribute program inputs to outcomes.

FINDINGS: We reviewed all identified impact and outcome evaluations to assess their research design, program characteristics, and evaluation results. The majority of the studies were quasi-experimental designs with a comparison group. The most commonly measured outcomes were increase in knowledge, favorable attitudes, and discussions about family planning, contraceptive use, and decrease in unintended pregnancies. Program interventions ranged from improving quality of care and accessibility of family planning methods to mass media, interpersonal communication, outreach campaigns, and public-private sector partnerships. The programs varied in the use and type of theoretical foundation, target population, and intervention site; however, they all had in common the explicit promotion of family planning use.

KNOWLEDGE CONTRIBUTION: The synthesis of family planning program evaluations provides a look into the specific factors that may impact program effectiveness. Program managers and policy makers can use these findings to inform evidence-based decision-making for program design, strengthening, and scaling up.

F04: 3
Scaling-up Community-based Distribution of Injectable Contraceptives in Uganda: Lessons Learned from Private and Public Sector Implementation
Angela Ako1, Amanda Abbott2, Kirsten Krueger2, Patricia Wamala1
1Family Health International Uganda, Uganda; 2Family Health International, North Carolina, USA; aakol@fhi.org

Background/Significance: Uganda is at a critical juncture for addressing its health, economic, and social development goals. At the center of this struggle is the limited improvement noted for access to, and use of, family planning. Effective and innovative service delivery strategies that reach rural populations are vital to addressing the country’s family planning problems. Community-based distribution (CBD) of injectable contraceptives is one such approach.

Following dissemination of the results of a pilot study that confirmed that community-based workers (CBWs) could safely provide injectable contraceptives in the community, interest was generated to scale up CBD of Depo Provera to other parts of the country. With the endorsement of the Ministry of Health and
International Conference on Family Planning: Research and Best Practices

funding from USAID, Family Health International provided technical assistance to two public sector and two non-governmental CBD programs in Uganda. Evidence of successful scale-up with these programs is important for generating recommendations for national guidelines review and wide scale implementation.

To generate this evidence, we were guided by the following questions:

• What are the lessons learned from Uganda’s recent scale-up of community-based provision of Depo Provera in both public sector and NGO-run community-based family planning programs?

• How well can relatively under-resourced government administered community-health programs, introduce community-based distribution of Depo Provera in comparison to NGO-run programs?

Methods: We documented the process of scale up and examined service statistics over one year of implementation of CBD programs in four rural districts of Uganda. Findings: A total of 1,364 women received Depo Provera from 44 public sector CBWs over at 12-month period, providing 799 years of protection, or an average of 18 years of protection per CBW. The majority of women (57%) were first-time users of Depo Provera, although many (43%) had formerly accessed it through a clinic. Over a comparable six-month period, each CBW in the public sector provided 10 years of protection to couples, whereas each private sector CBW provided 7 years of protection. In the public sector, re-injection rates were relatively high: 72 percent at 3-months, 70 percent at 6-months, and 84 percent at 9-months. Moreover, 92 percent of these clients received their re-injections within the recommended timeframe. Finally the rate of injections reported with needle related injuries was 0 percent.

Both public and private sector programs have shown that CBD of Depo Provera can be easily integrated into their existing services. Moreover, women, their husbands, clinic providers, and program managers are satisfied with the services and want them to continue into the future. Conclusion: Based on these findings it is recommended that the Ministry of Health review the national service guidelines to consider supporting provision of injectables by CBWs with all types of service delivery organizations (both private and public sector) so as to maximize all existing opportunities.

FO4: 4

Findings from a Qualitative Study of a Pilot Community-Based Distribution of DMPA Program

Heather Lukoyo, Pamela Mukaire, Paige Anderson Bowen, Laura C. Ehrlich

Minnesota International Health Volunteers, United States of America; lehrlich@mihv.org

Background

Minnesota International Health Volunteers (MIHV) is a U.S.-based organization implementing community-based family planning in Central Uganda. MIHV conducted qualitative research to explore factors contributing to a successful pilot community-based distribution (CBD) of depot medroxyprogesterone acetate (DMPA) program in Mubende District.

Intervention

To expand service delivery and increase demand for family planning (FP) in a rural, resource-poor setting, MIHV collaborated with Ssembabule and Mubende District health teams to train 265 volunteer family planning community health workers (FPCHWs) in 2006 and 2007 to promote FP, distribute FP methods (condoms, oral contraceptive refills, CycleBeads), and counsel/refer FP clients. To expand method mix, MIHV followed a few other organizations in Uganda in piloting a CBD of DMPA program. Beginning in June 2008, MIHV trained 60 FPCHWs in Mubende District in CBD of DMPA, resulting in 870 units of DMPA dispensed (506 new users; 364 revisits) and 217.5 couple years of protection in the first 10 months. DMPA clients reported high levels of satisfaction with no injection morbidities or needle sticks noted.

Methodology

To understand factors contributing to program success, MIHV conducted qualitative research in March-May 2009. Key informant interviews (n=19) with FPCHWs, CBD of DMPA clients, and district health workers/officials and focus groups (two groups; n=13) with CBD of DMPA clients explored: client experiences with service providers, provider experiences with clients, health workers’ attitudes towards and observations of FPCHWs, and stakeholder perspectives about program progress. All respondents signed informed consent forms. All interviews and discussions were conducted in Luganda, recorded, transcribed, and translated into English. Key themes were identified and thematic analyses conducted.

Findings

High levels of client satisfaction with CBD of DMPA services were attributed to:

• Accessibility and convenience: Clients appreciated proximity to their homes, shorter waiting times, and reduced/eliminated transport costs compared to health facilities.

• Privacy and confidentiality. Clients preferred the private environment of FPCHWs’ homes and some favored being able to conceal their DMPA use from others, including husbands.

• Free of charge provision: Clients appreciated free access to DMPA, and reported paying for services at private clinics and sometimes at public health facilities.

Factors contributing to high quality and safety of FPCHWs’ service provision:

• Thorough counseling: FPCHWs unhurriedly counsel, explain how various FP methods work and prepare clients for side effects.

• Demonstration of DMPA vials: FPCHWs show DMPA vials to clients before use, so they can see that it is new and unexpired.

• Scheduling of next appointment: FPCHWs provide written appointment notes for the next injection and give reminder phone calls.

• Good customer service: FPCHWs are reported to be friendly, approachable, and patient with clients.

• Adequate injection hygiene: FPCHWs practice adequate hygiene, including hand-washing in front of clients.

Respondents expressed high levels of confidence in using the “non-clinically trained or lower qualified” cadre of health workers to provide DMPA in a community-setting. Confidence was grounded in the comprehensive training FPCHWs received and demonstrated ability to provide quality service.

Stakeholders (district health team, local leaders, health workers, religious leaders) advocated for and worked to integrate program components into the district health system structure for ongoing sustainability. Within communities, mixed reactions about CBD of DMPA and FP were partly related to myths about FP combined with cultural and social norms like lack of male support and involvement.
Anecdotal evidence showed the CBD of DMPA program generated new demand for DMPA and satisfied existing unmet need for the method. Several women reported switching from shorter-term FP methods (e.g. condoms and pills) to DMPA, as the service became more accessible.

Challenges reported by respondents included:

- Shortage of FPCHWs trained in CBD of DMPA to adequately cover large areas.
- Inconsistencies in DMPA supply at the health facility level and FPCHWs’ difficulties obtaining transport to the health facility to restock.
- Demotivation of FPCHWs not selected for CBD of DMPA training.
- Low levels of client referrals indicating a need to provide refresher training to FPCHWs on referrals for side effect management and to strengthen the referral system.
- Poor male involvement and non-disclosure of DMPA use to partners.
- Persistent myths and misconceptions related to FP in general and DMPA.

Knowledge Contribution

These findings demonstrate factors leading to preliminary success of a CBD of DMPA program and provide an understanding of how FPCHWs, clients, health workers, and other stakeholders view a CBD of DMPA program in a low-resource setting. The findings point to the need for more behavior change communication around partner disclosure of family planning use and greater male involvement. Additionally the findings demonstrate that introducing DMPA into a new or existing CBD program requires adequate technical training of community health workers, continual and supervised practice, ongoing support, and adequate DMPA supplies. A CBD of DMPA program is an appropriate model for resource-limited settings to provide high-quality services and increase access to family planning.
Tuesday, 17 November 2009

AO5: Neglected FP Issues

Time: Tuesday, 17 November 2009: 9:30am - 11:00am

AO5: 1

The stalled fertility transition and family planning in Kenya

Jan David Askew¹, Alex Ezeh², John Bongaarts³, John Townsend³

¹Population Council, Kenya; ²African Population and Health Research Centre; ³Population Council, USA; iaskew@popcouncil.org

Background/Significance:

Recent surveys indicate that the fertility transition appears to have stalled in a number of African countries. Kenya is one of these countries, which surprised many observers given the rapidity of the early fertility decline and the relative strength of the family planning program compared with other African countries. The stalled fertility transition has been accompanied by a stall in the overall contraceptive prevalence rate, indicating the important association between family planning and fertility in Kenya.

Main research questions:

This paper seeks to: review the existing evidence and offer analytical perspectives on the magnitude and distribution of the fertility transition in Kenya; identify key policy and programmatic efforts for strengthening family planning and their perceived effectiveness within various socio-demographic settings; recommend investments that could stimulate appropriate changes in programming family planning efforts; and highlight lessons relevant for other African countries experiencing similar stalls in contraceptive prevalence and fertility.

Methodology and data:

This paper presents a meta-analysis of the existing literature on demographic trends, patterns in family planning use and relevant policy initiatives in Kenya over the past 20 years. Statistical data are largely drawn from the series of Demographic and Health Surveys and programmatic and policy experiences from unpublished and published documents.

Findings:

The total fertility rate declined rapidly between 1977 and 1998, probably due to a strong family planning programme that focused on both providing contraception (to reduce unwanted fertility) and creating a demand for family planning (to reduce wanted fertility). It then increased in 2003, especially among those with no education and in the lowest wealth quintile, while fertility continued to decline among the most educated. Unwanted fertility had declined rapidly by 1998, probably due to an expansion in the availability contraception. The decline then stalled and increased slightly in 2003, probably due to a sustained diminishment in the effectiveness of the public sector delivery systems, including withdrawal of community-based distribution of contraceptive services. This increase in unwanted fertility was highest among the poorest quintile. Wanted fertility also declined rapidly, probably because of the tremendous investment in information and education campaigns, but then increased slightly. This increase in wanted fertility occurred primarily among the poorest and least educated, which were also those most adversely affected by increasing rates of child mortality and HIV/AIDS infection. Contraceptive prevalence increased rapidly to a high of 30% percent among women (39% among currently married women) by 1998 but did not increase any further, which reflects both the stall in declining wanted fertility and a lack of investment in family planning information and services. Contraceptive prevalence continued to increase among all sexually active women, suggesting that women who were sufficiently motivated and had the resources were able to access and use contraceptives. Contraceptive prevalence decreased significantly among women with no education and with no children, but increased among the more educated. The mix of methods reduced drastically, with injectables replacing the pill and LAPMs for both spacing and limiting births. Provision of family planning services has shifted increasingly to the private sector, with short-acting methods being the principle contraceptives available and referral systems for clinical services poorly defined. Whether the HIV/AIDS epidemic has influenced the fertility transition and patterns of family planning use is unclear and needs greater understanding.

Knowledge generated / lessons learned:

These analyses suggest the following lessons: investment in family planning policies and programmes must consider both reducing unwanted fertility and addressing determinants of wanted fertility; non-clinic based programmes are important for both delivering contraceptives and influencing fertility preferences; in a country where half the population lives below the poverty line, family planning information and services must be “pro-poor” and support other poverty reduction strategies, including education; and, child survival appears to be associated with fertility intentions and so family planning needs to be linked with infant / child health services, as well as maternal health services. Provision of family planning information and services must be based on a firm understanding of fertility preferences and intentions; Kenya’s stalled transitions in fertility and family planning use may reflect the achievement of desired family size by a large proportion of the population, in which case investments in family planning need to balance the goals of reducing unwanted fertility with addressing current levels of wanted fertility that are above replacement level. Kenya has long been a regional leader in developing strong population-related policies, as well as norms, standards and guidelines for service delivery. Lessons learned from Kenya may be pertinent for many countries in the region facing similar fertility and family planning stalls.

AO5: 2

Family Planning in sub-Saharan Africa: Progress or Stagnation?

John Cleland¹, Robert Peter Ndugwa², Eliya Zulu²

¹London School of Hygiene and Tropical Medicine, United Kingdom; ²African Population and Health Research Center, Nairobi Kenya; robert.ndugwa@lshtm.ac.uk

Background/Significance:

Many commentators have expressed concern that the fertility transition in sub-Saharan Africa appears to have slowed down and, in a few countries such as Kenya, may have stalled. Fertility trends in Africa do not correspond with rises in modern contraceptive use as closely as in other regions; for instance, several West African countries have experienced a drop of one birth in their total fertility in the absence of any appreciable change in contraceptive practice. Nevertheless in those few African countries to have seen major falls in fertility (eg South Africa, Zimbabwe, Kenya (1980-1995) use of modern contraception is clearly the main proximate determinant.

Hypothesis:
The assumption of this paper is that, as in other regions, sustained fertility decline will be driven by mass use of effective contraception. The aim of this paper is to review progress, or lack of progress, towards mass uptake of contraception using Coale’s succinct summary of the preconditions for fertility transition as amended by Lesthaeghe and Vanderhoft (2001) as our conceptual framework: couples must be “ready, willing and able” to use contraception. Measures of readiness (or need/demand), willingness (favourable attitude) and ability (knowledge of methods and supply sources) are available in Demographic and Health Surveys (DHS). The analysis is initially confined to fecund, currently married and cohabiting women.

Methodology:
The following measures are considered;

- Need or Demand (readiness)
- Trends in % wanting no more children, standardized by living children (0-2, 2-4, 5+), education (no education or incomplete primary, complete primary or secondary+), residence (urban, rural)
- Trends in % wanting to delay next child for 2+ years, standardized by length of open interval (0-11, 12-23, 24-35, 36+ months), education, residence
- Knowledge and Access (ability)
- Trends in % knowing Pill and injectables, standardized by education and residence.
- Trends in % knowing where to access family planning, standardized by education and residence.
- Trends in % exposed to mass media FP messages, standardized by education and residence.
- FP Discussion (willingness)
- Trends in % who discussed FP at least once with husband in the past year, standardized by education and residence
- Approval and Intentions (willingness)
- Trends in % of couples where wife approves of FP and reports that husband approves, standardized by education and residence
- Trends in ever use and current use of modern contraception, standardized by education and residence.
- Trends in current use of modern contraception, standardized by education and residence.

Data:
For 19 African countries, at least two, and more usually three, DHSs have been conducted. Use of these data permits an examination of trends from about 1990 to 2003.

Findings:
Preliminary results show that for many countries, the percentage wanting no more children has increased or stagnated while knowledge of Pills and injectables which are the most commonly used methods in most African countries has increased among currently fecund married or cohabiting women. The percentage of women who discuss family planning at least once with their spouse in the past year has increased in many African countries.

Knowledge Contribution or Lessons Learned:
The findings will provide an ideal broad overview of progress and current prospects for widespread use of contraception in Africa.

A05: 3

Infertility: the hidden tragedy within family planning" OR "Tossing the family planning coin, infertility exposed: Perhaps an evenly-weighted coin will prove best practice?"

Sheryl Vanderpoel
World Health Organization, Switzerland; vanderpoels@who.int

(1) Background/Hypothesis
Detrimental to current initiatives in family planning is the assumption that “family planning” implies either contraception or mechanisms to decrease the number of unwanted pregnancies. In order to change tact, to alter perceptions and to revitalize family planning, then perhaps a more holistic and realistic approach is required. Family planning is about planning a family, therefore family planning messaging may need to change. For many couples contraception is not the only unmet need to realize their ICPD reproductive rights in a safe and responsible manner. The unmet need on the other side of the ‘family planning’ coin must be addressed: fertility problems. Stigmatizing conditions that can be greatly feared by couples are the lack of pregnancy and male sub-fertility, especially in countries where motherhood is a critical psycho-social component of belonging within a local community and where fulfilling maleness is based on proof of virility.

(2) Significance
The unmet need for family planning (“contraception”) is quoted to affect 137 million women. However, based upon the 2004 DHS Comparative Report completed in collaboration with WHO-RHR, “Infertility, infecundity and childlessness in developing countries,” it was found that 186 million women have an unmet need for infertility services. Consistently, across many cultures and regions, the women is often blamed for lack of pregnancy, although one or both members of a couple could be the cause. What rights to ICPD reproductive choice do a couple have, if they desire a child, or a second child to realize their desire of a small family, but they are bombarded with contraceptive messaging because their neighbour has six children? With lack of access to infertility services but only one side of the coin of family planning being promoted, how do these individuals cope?

(3) Methodology and Findings (reports/reviews)
Attempts to become pregnant or prove virility often manifest themselves in seeking multiple partners, which exacerbates problems of transmission of STI, HIV and other infectious diseases - this behaviour does not save lives. Reported sexual violence within couples, depression and marriage breakdown have been linked to fertility problems, as frustration in the inability to and pressures to produce a child (or that second child) become unbearable. These are the lost or hidden faces of women and men who remain divorced/single or become single parents, may be unable to step on fertile ground, attend ceremonies or be buried in the ground for fear they will be contaminating or rendering infertile whatever or whoever they touch or come near. Reporting on fertility problems are likely under-represented, because even admitting infertility can be stigmatizing, or those in the family who would report a fertility problem may be kept hidden.
What do couples in communities think and see? Family planning is surrounded by myths: Some myths claim that the temporary infertile condition which is manifested by contraceptive use can result in permanent infertility or fertility problems following the discontinuation of a contraceptive method. Indeed, fertility problems often do become an issue after a first pregnancy or a child is born. Secondary infertility, the inability to become pregnant after having had a previous pregnancy, is often a result of post-partum infection, post-abortion infection, iatrogenic infertility, STIs and other infectious diseases. However, if oral contraceptives are initiated after an abortion, or post-partum following a first pregnancy, and done so without dual protection (condom use) within non-monogamous relationships, STIs could be contracted which affect fertility directly or can result in fallopian tube, vas deferens or epididymal tubal damage resulting in the long term sequelae of secondary infertility in women or result in sub-fertility in men. Thus, myths are silently perpetuated, and, contraceptive methods are viewed with scepticism if use and consequence are misunderstood.

(5) Methodology and Findings (Statistical analysis)

The 2004 DHS study of 47 developing countries, evaluating surveillance data from 1995 to 2000, showed a significant prevalence of secondary infertility. We have revisited and extended this study evaluating data from 1995 to 2005 and show that secondary infertility prevalence rates remain high, affecting 25-30% of the surveyed populations in affected countries especially in sub-Saharan Africa. Why do these high rates of secondary infertility persist?

(6) Knowledge contribution/Lessons learned

Revitalizing contraceptive services, education and messaging within primary health care systems in the name of “family planning” must: (1) be done in concert with infertility and sub-fertility issues being addressed and (2) incorporate messaging about responsible reproductive decision-making.

When tossing the family planning coin, it should not land on a heavier side of contraception choice - as it will continue to expose the opposing side, the lack of choice and access to infertility services. Recognition of the reality of community life and reproductive choice, and appropriately addressing the unmet needs of couples on both sides of the “family planning” continuum is required — to make a difference and save lives.

A05: 4
Population and Health in National Adaptation Programmes of Action (NAPAs) for Climate Change
Clive J. Mutunga, Karen Hardee
Population Action International, United States of America; cmutunga@popact.org

1) Background/Significance

Adapting to climate change will entail a variety of responses, including policies to improve management of climate related risks by enhancing adaptive capacity while at the same time easing pressure on resources. The pressure on resources has been linked to a number of causes, key among them population dynamics. Thus, adaptation policies that consider interventions aimed at slowing the rate of population growth will yield a “win-win” opportunity, address adaptation needs in the short term while building long-term sustainability by reducing pressure on the environment.

Recognizing that least developed countries (LDCs), including small islands developing states, are among the most vulnerable to extreme weather events and the adverse effects of climate change, National Adaptation Programmes of Action (NAPAs) were established as part of the Marrakech Accords of the 2001 Conference of Parties (COP) to the United Nations Framework Convention on Climate Change (UNFCCC). NAPAs were intended to provide assistance to countries with the least capacity to cope with the adverse effects of climate change in developing plans to address the adverse effects. NAPAs provide a process for LDCs to identify priority activities that respond to their urgent and immediate needs with regard to adaptation to climate change. These urgent and immediate needs are those for which further delay could increase vulnerability or lead to increased costs at a later stage.

2) Hypothesis or Intervention/Activity Tested

What is the experience with NAPAs to date among least developed countries and small island states? What interventions are being included in NAPAs? Is population pressure and interventions aimed at slowing and stabilizing it addressed in NAPAs, including through projects proposed by countries?

3) Methodology/Data

This paper reviews 39 National Adaptation Programmes of Action (NAPAs) submitted as of December 2008 by Least Developed Countries (LDCs) to the United Nations Framework Convention on Climate change (UNFCCC). The review assesses the NAPA process to identify the range of interventions included in countries’ priority adaptation actions and how population issues are addressed as part of the LDCs adaptation agenda. Information on the submitted NAPAs was assembled by the authors into an Excel database of all the projects. Analysis focused on this database and on content analysis of the NAPAs. This information was supplemented through a review of literature on NAPAs, adaptation to climate change and the relationship between population and climate.

5) Findings

The review found near-universal recognition among the NAPAs of the importance of population considerations as a central pillar in climate change adaptation. 35% of the NAPAs link high and rapid population growth to climate change. However, this appreciation is not matched with a proportional identification of adaptation interventions; indeed only six NAPAs explicitly state that slowing population growth or meeting an unmet demand for family planning should be a key priority for their adaptation strategy. Furthermore, among those NAPAs that clearly make this case, only one actually proposes a project with components of family planning and reproductive health among its priority adaptation interventions. Most NAPAs focus priority attention on projects to promote food security and water resources. No health projects have received high enough priority to receive funding.

The low priority of health projects reflects the NAPA guidelines, which in spite of their recommendation concern with the importance of aligning projects to long-term sustainable development planning, place greater focus on meeting immediate needs through short-term projects.

6) Knowledge Contribution or Lessons Learned

This review leads to five general recommendations:

- The focus of NAPAs on short term projects over linkages with development strategies that address medium and longer-term issues is short sighted. Climate change will continue for years, and not all adaptation issues can be addressed through short-term projects. Therefore, a mix or short- and longer-term projects that incorporate participation across development sectors is important to ensure a wide range of adequate responses in adapting to climate that saves lives and, ultimately, strengthens livelihoods.

- NAPAs should translate the recognition of population pressure as a factor related to countries’ ability to adapt to climate change into relevant project activities. Such projects should include access to family planning and reproductive health (FP/RH), in addition to other strategies such as, for example, girls education, women’s empowerment, and a focus on youth, that lead to lower fertility.
• The favoring of single sector projects within the NAPAs over integrated programs does not reflect people’s lives. Strategies for adaptation should reflect a multisectoral approach that recognizes that people’s lives are not lived in single sectors. People deal simultaneously with food, water, livelihoods, health, and education, among other issues, including fertility. Wherever appropriate, projects or programs funded through NAPAs should be integrated across sectors to avoid “winner” and “loser” sectors in the priority-setting stage of NAPA development and funding.

• Integrated climate adaptation programs that address population in addition to a range of other issues, including access to food and water, should be included in NAPAs and given high priority for funding.

• Countries that have already clearly identified FP/RH projects in their NAPAs should expedite the development and implementation of these projects.

B05: Commodity Security II

Time: Tuesday, 17 November 2009: 9:30am - 11:00am

B05: 1
Contraceptive Security: Incomplete without Long-Acting and Permanent Methods of Contraception
Jane Wickstrom, Roy Jacobstein, L. Subramanian
Engender Health, United States of America; jwickstrom@engenderhealth.org

Significance Contraceptive security—when people have regular, reliable, and affordable access to a choice of contraceptive methods to meet their reproductive health needs—is of vital importance to family planning (FP) programs. Widespread availability and use of long-acting and permanent methods of contraception (LA/PMs)—the hormonal implant, the intrauterine device (IUD), female sterilization, and vasectomy—are needed for countries to cost-effectively lower fertility; meet their Millennium Development Goal for maternal health and child survival; and address other economic and development goals. Yet few contraceptive security plans clearly articulate the requirements for providing LA/PMs.

Main Question FP programs and reproductive health commodity security initiatives often neglect the commodities, equipment, and supplies needed to support or scale up the use of LA/PMs, which in turn makes it difficult for FP programs to meet their clients’ reproductive health intentions. When LA/PMs are infrequently offered and used, program managers do not plan for all that is needed to provide these methods, which leads to fewer requests for the specific equipment, supplies, and training opportunities needed to offer LA/PMs effectively. This cycle of “nonuse” for IUDs, vasectomy, and female sterilization makes it difficult for providers to confidently offer these methods as their clinical skills diminish with lack of practice and commodity availability. Clients thus receive little LA/PM information or support from friends, the community, and/or providers, in which turn creates a self-fulfilling prophecy that “clients don’t want IUDs or sterilization.” Yet when asked in surveys, many clients state that they want to delay, space, or limit births and intend to use FP. Significant increases in use of Depo-Provera injections and hormonal implants fill some of the unmet FP need, but stock-outs of these methods are common, limiting client choice further. The main question is: How do contraceptive security strategies and initiatives help or hinder access to LA/PMs? And how might contraceptive security initiatives improve access to and use of LA/PMs?

Methodology The authors reviewed quantitative as well as qualitative information to determine current trends in LA/PM use and assess how contraceptive security initiatives could support greater use of LA/PMs. National contraceptive security strategies were reviewed to determine if these strategies were meeting the requirements for LA/PM commodities and services.

Findings/Data According to the World Health Organization’s latest Medical Eligibility Criteria for Contraceptive Use, almost all women can use IUDs, implants, and/or sterilization, and almost all men can use vasectomy—yet actual use of these methods in resource-poor settings is limited. One factor in an array of programmatic issues that limit LA/PM use is that contraceptive security initiatives do not usually focus on the ordering, supply, equipment, training, supervision, and financial support needed to expand access to these highly effective methods. Analyses of Demographic and Health Survey data showed that clients’ intentions to delay, space, or limit births were not being met: Many respondents are either not using FP at all or are using methods that have relatively high failure rates (condoms, 12%; pills, 8% during typical use).

Programmatic data and experience show that paying greater attention to meeting the requirements of LA/PM services can lead to greater LA/PM access and use. For example, in Egypt, IUD use rose from 1.5% of married women of reproductive age (MWRA) in 1980 to 36% in 2005; Jordan, Turkey, and Vietnam experienced similar high rates of IUD use due to programmatic commitment to supporting IUDs. Even in Sub-Saharan Africa, where LA/PM access is more limited, hundreds of thousands of people use LA/PMs when such methods are made available, especially when cost and other access barriers are removed. Evidence from Ghana, Kenya, Malawi, and Tanzania confirm this observation. For example, Malawi’s openness to using clinical officers to provide female sterilization led to a notable rise in use, from 1.7% among MWRA in 1992 to 4.7% in 2000 and to 5.8% in 2004. More work is needed to meet fertility intentions. In Ghana, 24% of MWRA want no more children, but only one out of 10 uses FP to limit future births. Only one-quarter of women who want no more children are using an LA/PM, while 25% use traditional methods.

Lessons Learned While the principle of providing a broad choice of methods in FP programs is universally accepted, LA/PMs are not given the support needed to make them widely available. Evidence shows that LA/PMs will be used on a large scale when trained providers have the equipment, supplies, and contraceptive products available within a supportive program environment. Sustaining a focus on the fundamentals of care (informed, voluntary choice, clinical safety, and ongoing quality improvement), including for LA/PMs, is crucial to programmatic success. What is needed is a clear contraceptive security strategy that follows best practices for fostering change and scale-up of FP services, including for wider LA/PM access and use, to meet clients’ needs and achieve sustained program growth.

B05: 2
The Procurement Planning and Monitoring Report: Towards Donor Coordination in Contraceptive Security
Trisha Long, Paul Dowling
USAID | DELIVER PROJECT, United States of America; tlong@jsi.com

1. Background/Significance

The Countries at Risk (CAR) Group of the Reproductive Health Supplies Coalition (RHSC) mitigates short-term supply crises to maintain contraceptive security in developing countries. The CAR group is comprised of donors, including the USAID group of donors, the United Nations Population Fund (UNFPA), the KfW banking group, the World Bank, and the Coalition Secretariat. Prior to September 2007, the group had no systematic way to obtain information about the contraceptive supply situation in countries. Members brought anecdotal reports of stock situations to the group; they took action on them, if possible. However, because the anecdotal reports were often out-of-date, the group frequently had to go back to their contacts in-country for more
information before they could take action, thus delaying the response time. The lack of data hampered the group’s efforts to effectively identify and address shortages, over-supplies, or stockouts of contraceptives.

2. Activity tested

In 2007, the USAID DELIVER PROJECT began working with members of the CAR Group to develop a reporting system that would provide regular stock status updates from countries around the world. The end result has become known as the Procurement Planning and Monitoring Report (PPMR), a monthly report in which countries (currently fourteen) provide updates on stock levels of contraceptives managed by the public sector and sometimes by social marketing.

3. Methodology

Data for the PPMR are collected primarily from the in-country offices of USAID projects that use Adobe pdf forms. These forms produce data files that are uploaded into a database, and then used to produce the report. Countries submit data either monthly or quarterly, depending on their reporting schedules. Key data items include stock levels in months of stock (a calculation that divides the quantity of stock on hand by the average monthly consumption to estimate how long supplies will last), the date of the next shipment and its supplier, the level of the supply chain reported, and any actions that the countries recommend donors take. The recommended actions guide the CAR Group’s monthly discussions of critical issues.

4. Data

Collaborative actions that resulted from PPMR information included transfers of IUDs between Mozambique and Rwanda, and later between Malawi and Kenya. In each case, the transfer reduced the possibility of a loss due to expiry in the sending country, and mitigated a stockout in the receiving country. In another instance, a donor agency agreed to provide urgent commodity assistance to a country facing stockouts.

Data from the PPMR also show that the methods most frequently stocked out from January 2008 to April 2009 included combined-oral contraceptives and IUDs, but female condoms stocked out for the longest durations in two African countries.

5. Findings

The PPMR database is a rich source of historical stock-level data for the countries in the report. Initially, countries were asked to report stock data from their central level warehouses only because of concerns about the reliability and availability of data from the lower levels. A few countries with more robust monitoring systems are now providing data from the lower levels of the supply chain, increasing knowledge about the country’s overall supply situation. USAID project country offices are encouraged to share the report with relevant in-country stakeholders, such as ministries of health, USAID Missions, and UNFPA country offices. Sharing this information increases the visibility of critical stock situations for all partners, enabling mitigating actions to be better coordinated.

6. State lessons learned

Data are collected from either the country offices of the USAID DELIVER PROJECT, or from the Management Sciences for Health’s (MSH) Strengthening Pharmaceutical Systems Project (SPS). Other countries where these two projects do not operate are encouraged to submit reports, but it has been difficult to get access to their data. Awareness-raising is needed to encourage countries to share their data for the report, but it is also often difficult to ascertain the quality of these data, creating difficulty in using them for decision-making.

The PPMR’s ultimate goal is to provide complete transparency into all levels of the supply chain in developing countries. While the PPMR only covers a limited number of developing countries, and mainly supplies at the central level, it does help inform global partners of supply situations in those countries, and it can encourage a response to short-term emergency stockouts. By highlighting potential problems, it can also be a catalyst for country stakeholders to act.

The ability of the CAR and the global community to respond to stockouts of contraceptives is limited. Few donors have readily available supplies that can be quickly moved. With limited ability to provide tangible benefits to countries that submit data, the PPMR’s reach is constrained.

B05: 3

Health Sector Reforms and their Effects on Contraceptive Security: The Case of Malawi

Jayne Waweru, Samuel Chirwa, Sury Sacher, Manondo Msefula

1USAID | DELIVER PROJECT, United States of America; 2Malawi Ministry of Health, Health Technical Support Services, Pharmacy Department; ssacher@jsi.com

1. Background/Significance

In an environment of recent health sector reforms, it is important to ensure that reproductive health and contraceptive security remain prioritized. Recently, an increasing number of countries have begun to use sector wide approaches (SWAps) and their associated financial mechanisms to promote national ownership and coordinate donor contributions. Despite some advantages, SWAps can also mean challenges for reproductive health. For example, family planning must increasingly compete against other health priorities for limited resources. As a result, policymakers often prioritize particular health conditions over others—frequently placing more importance on curative health products, such as antibiotics, as opposed to preventive products, such as contraceptives. In addition, more countries are moving toward decentralization, which poses similar risks.

In late 2004, Malawi began using the SWAp and related financing for its health sector. In addition, funding is also now being allocated directly to each of 27 districts. The central government earmarks funding to ensure that districts allocate resources to health, while the districts determine how to divide those resources. While there have been many advantages, implementation of the SWAp and related financing, as well as decentralization, have proven difficult for Malawi—especially for family planning supplies. For example, in 2006 the districts began purchasing injectable contraceptives directly from the Central Medical Store (CMS). In spite of initial challenges, the government was able to adequately finance and successfully conduct several procurements. However, recently, the country has again experienced challenges with delays in procuring the contraceptive injectable depo-methoxyprogesterone acetate (DMPA); these delays are due to prolonged procurement processes, uncertainty regarding the ability of the districts to procure the commodity from the CMS, and lack of adequate SWAp funds because of competing priorities. In this case, USAID—a donor that has remained outside the basket funding mechanism and, therefore, has the flexibility to step in during urgent situations—supported an emergency procurement of DMPA. Furthermore, because of decentralization, family planning stakeholders are concerned that district health officers—faced with stockouts of other essential drugs and commodities—might decide not to purchase injectable contraceptives.

2. Main question

What are some of the unintended consequences of decentralization and SWAps on family planning and contraceptive availability?

3. Methodology

The USAID DELIVER PROJECT conducted an analysis of routine stockout data from the logistics management information system (LMIS). In addition, the project visited 112 health facilities (27.9 percent of public sector health facilities) in 15 districts to validate the stockout rates reported and to collect qualitative
information that could explain the health facility stockouts of DMPA despite the sufficient stock available at both the CMS and regional stores. DMPA was identified as the focus of this analysis because it accounts for 64 percent of modern contraceptive use in the country.

4. Findings

Findings from the analysis indicate a gradual increase in the number of public health facilities stocked out of DMPA. The findings suggest that as the district drug budgets become tight, procurement priorities favor cheaper essential drugs, curative services are prioritized over preventive services, and districts resort to rationing their orders. This becomes especially problematic for DMPA because it is the most costly essential drug required at health centers.

5. Lessons learned:

• Implementation of a SWAP and decentralization may have the unintended consequence of making it more difficult to mobilize leaders to fund family planning because there are many competing demands. It is important to lobby for pooled funds to be allocated specifically for contraceptive security.

• Careful planning is needed to ensure that management capacities for the financing and procurement of contraceptives are carefully transferred to the government. Providing capacity building and strengthening local procurement systems can lead to host country government ownership of contraceptive security.

• Countries should be prepared for emergency procurements during the transition to government procurement. Donors who use funding mechanisms outside basket funds and governmental budget support can implement procurements faster than national programs or pooled funding mechanisms. Although the change to government procurement of commodities may lead, at first, to delays and stockouts and, therefore, undermine contraceptive security, as national procurement capacity increases, emergency situations should become less frequent.

• Decision makers at the district level may initially lack the awareness of issues affecting contraceptive security. Training and some central-level oversight may be needed.

B05: 4

The Strategic Pathway to Reproductive Health Commodity Security: Five years and 50 countries later—What have we learned?

Leslie Patykewich, Marie Tien
USAID | DELIVER PROJECT, United States of America; lpatykewich@jsi.com

1. Background/Significance

Although progress is being made in many countries to improve reproductive health, work is still needed to continue the advances already in place. The use of modern contraception is increasing in the developing world: use of modern methods by married women increased from 53 percent in 1994 to 62 percent in 2007 (Guttmacher 2008). While sub-Saharan Africa mirrors this global trend, with a few notable exceptions (i.e., Madagascar, Rwanda, and Ethiopia), the gains are modest; in most sub-Saharan African countries, the number of women with an unmet need for family planning is higher than the number using contraception. Furthermore, unmet need is actually increasing in some countries (i.e., Benin, Kenya, and Uganda.)

These indicators show that there is still much progress to be made in improving family planning and reproductive health commodity security (RHCS), which is defined as existing when every person is able to choose, obtain, and use quality contraceptives and other essential reproductive health products whenever s/he needs them.

To improve reproductive health, many countries are working to strengthen the provision of commodities. The Strategic Pathway to Reproductive Health Commodity Security (SPARHCS) has played an important role in assisting countries in these efforts. SPARHCS was developed with input from more than 40 nongovernmental organizations (NGOs) and donor agencies, including USAID and UNFPA. The SPARHCS process examines the various components that are involved in securing reproductive health commodities: context, commitment, financing, coordination, capacity, and client demand and use. SPARHCS assesses the current RHCS situation and identifies strengths and weaknesses. The findings are used to gain consensus on priority areas and help to generate commitment to address these issues. Since its development in 2004, various stakeholders, policymakers, and development partners have used it as both a process and framework to help organize the multiple components required to improve RHCS.

2. Main question/hypothesis

a. How does the SPARHCS process help countries address commodity security issues?

b. What are the ongoing challenges in using SPARHCS to strengthen RHCS?

c. What has the reproductive health community learned from the application of SPARHCS in more than 50 countries?

d. What are continued challenges in addressing commodity security?

3. Methodology

As a result of the SPARHCS process, countries have seen various degrees of progress. To assess the value of SPARHCS, this paper examines both the successes and lessons learned based on the application of this approach in more than 50 countries. This examination reviews SPARHCS activities that have been sponsored by a variety of funders, including UNFPA and USAID. It explores the positive and negative aspects of the process, as well as successes and challenges in serving its overall purpose—improving RHCS.

4. Findings

During the past five years, contraceptive security and the SPARHCS tool have inspired a number of distinct methodologies for assessing RHCS, determining priorities, and using findings from assessments to develop and implement strategic plans to improve product availability. During the course of this implementation, key partners have identified several contextual factors that may require further attention in the commodity security approach. For example, while countries are decentralizing many of their health system functions (such as financing, coordination and policy implementation), efforts to address commodity security remain largely at the central level. Lower-level stakeholders often lack the capacity, awareness of, and commitment to issues affecting commodity security; they are not using a coordinated approach to address product availability. Another identified limitation is the lack of the client’s engagement in the CS process, despite the recognition that the client is the ultimate driver and beneficiary of improved CS. Additionally, in many countries, the private sector—a key stakeholder and partner in improving access to reproductive health supplies and services—is often not adequately engaged.

Last, while the uptake and expressed need for CS has been remarkable, a need to continue to work with partners remains and, in countries, to mainstream and adapt this concept and approach.
These and other lessons examine the value of SPARHCS in helping to improve a country’s RHCS situation. In addition, they provide a candid examination of the challenges countries face in implementing this approach.

5. Knowledge contribution

National stakeholders and development partners have utilized SPARHCS to meet the challenge of addressing all the components necessary to achieve RHCS in a holistic manner. SPARHCS provides the structure and tools for the long-term effort needed to attain commodity security.

B05: 5


Dana Aronovich, Disha Ali
USAID | DELIVER PROJECT, United States of America; daronovich@jsi.com

Background/Significance:

The concept of contraceptive security (CS), which means ensuring a supply of contraceptives so that every person is able to choose, obtain, and use quality contraceptives whenever s/he needs them, is a critical component of family planning (FP) programs. Without a reliable and high quality supply of contraceptives, programs cannot provide quality services to meet their clients’ needs.

The Contraceptive Security Index was developed to measure the level of CS in developing countries based on a set of 17 indicators that cover the principle components of CS, including health environment, finance, supply chain, access, and utilization. These indicators are compiled to establish a composite score for more than 65 countries around the world. Three versions of the index have been compiled, allowing for an analysis of CS over an extended period of time.

Main questions/hypothesis

1. What is CS and how is it relevant to FP program outcomes?
2. What changes and trends have occurred over time between the 2003 and 2009 CS Index at the national, regional, and global level?
3. How can the data from the CS Index be used to advocate for improved resource allocation by country governments, global donors, and lenders?
4. How can the data from the CS Index be used to identify priority areas for additional support by examining different indicators and components to inform program planning?

Methodology

To minimize data collection costs and to maximize data reliability, validity, and replicability, the CS Index uses only secondary data published from reliable sources that are regularly updated; using this data, the index can be updated approximately every three years. The selected indicators cover a range of inputs and outputs, and programmatic and macro-level areas. Taken together, they promote a multisectoral approach to addressing CS at the national, regional, and global level.

The data to calculate the CS Index were collected in 2003, then 2006, and again in 2009. The 2009 results will be published and presented to allow for monitoring overall progress within a country and for comparing individual countries’ progress over time.

Findings

Preliminary results show some global progress in moving toward CS since 2003; the data permit users to highlight broad areas of strengths and weaknesses. In particular, by studying trends in component scores for individual countries, stakeholders can identify general areas that need focused attention and resources and that may need more in-depth assessment. For example, countries can record similar total scores but have strengths or weaknesses in different components.

The average total CS Index score across countries increased from 51.4 in 2003 to 54.1 in 2006. Using a paired t-test, the 2006 total scores, averaged across all countries included in both the 2003 and 2006 indices, represented a statistically significant increase over the 2003 total scores. The spread of actual scores in the 2003 index (on a scale of 0 to 100) ranged from 28.1 to the highest calculated score of 68.1; in 2006, this range shifted upward to 35.5 as the lowest score calculated and 73.2 as the highest. This indicates overall improvement toward the ultimate goal of contraceptive security. The calculation of the 2009 index will be completed in July 2009, allowing for a first examination of that new data at this conference.

At the regional level, between 2003 and 2006, all regions have shown aggregate improvement across the five components of CS. However, these increases in the total index score were only significant in Asia and the Pacific, the Middle East and North Africa, and sub-Saharan Africa.

In terms of the global averages for the five components, there was also a statistically significant increase from 2003 to 2006 in every component. The finance component, comprising indicators that represent the prospects for government and household financing of FP services and contraceptives in a country, has consistently recorded the lowest scores. Both the supply chain component—representing the performance of the public sector supply chains that manage contraceptive supplies in countries—and the health and social environment component—representing the other factors in the broader environment that can affect the prospects of CS—have registered the highest scores overall in 2003 and 2006.

It will be interesting to see how these trends play out in the 2009 index and what the prospects for CS will look like as we enter the next decade.

Knowledge contribution

National and international stakeholders can use these results to emphasize the importance of contraceptive security for better family planning program outcomes and to monitor progress toward reaching this goal. The CS Index can be a strong tool for raising awareness about CS and the interrelationships between different program components. The results can also be used to set priorities and to advocate for more rational resource allocation by country governments and global donors to achieve a secure supply of quality contraceptives.

C05: Integrating FP and Maternal and Child Health I

Time: Tuesday, 17 November 2009: 9:30am - 11:00am

C05: 1

Introduction of Post Placental/Partum IUD insertion (PPIUD) in Lusaka, Zambia: Feasibility of training nurse midwives

Sarah Prager1, Joss Neukom1, Pratima Gupta2, Jolly Chilambwe3, Nomsa Siamwanza4, Maxine Eber5, B Vwalika6, Paul D Blumenthal1

1Population Service International; 2University of Washington; 3Society for Family Health; 4University of Zambia; 5Kaiser Oakland; pblumen@stanford.edu
Background/Significance: In many settings, Intrauterine Contraceptives (IUC) are an underutilized method of family planning. Among the various times when IUCs could be inserted, the immediate post-partum (post placental) period is a highly opportune and advantageous point at which insertion can be performed. However, there have been few successful programmatic experiences with this timing, especially in Africa. Training or appropriate personnel is critical to a successful program.

Intervention/Activity Tested: To explore the feasibility of training nurse-midwives in Post-Placental/Partum IUD insertion (PPIUD) in Lusaka, Zambia.

Methodology:
Nine nurse-midwives participated in a 9-day competency-based training in post-partum IUD insertion (PPIUD). The training occurred at the University Teaching Hospital, a high-volume, government referral hospital. The curriculum involved didactic and practical components, taught by US and Zambian providers. A novel, humanoid pelvic model was developed for classroom practice to achieve PPIUD insertion competency before moving to clinical practice. All nurses achieved model competency after 3 practice attempts. Patients were recruited 1) during antenatal visits, 2) in early labor or 3) in the post-partum ward. Informed, voluntary consent was obtained in all cases. All insertions during the training were supervised or, if necessary, performed by trainers experienced in PPIUD insertion.

Data: During the training period, 38 PPIUDs were inserted. There were no complications. The insertion could not be accomplished in two patients due to discomfort. One IUD removal occurred in a woman who had pain from a suspected symphysis separation. The trainer performed the insertion in only 5 patients. The nurses performed all other insertions under trainer supervision. By training’s end, 4 of the nurses were deemed competent to independently insert PPIUDs, including 2 who could train others in the future. On average, four insertions were needed to achieve competency.

Findings: Concentrated, competency-based training in PPIUD is feasible in an African setting. Replication of such trainings could make PPIUD, an underutilized approach to IUD insertion, more popular and prevalent. Post-training, demand for the services has increased and over the last 5 months PPIUDs are consistently provided at peri-urban hospitals.

Knowledge gained: Training in PPIUD is feasible for nurse-midwives working in peri-urban Zambian hospitals, and they are an appropriate cadre of health worker for sustaining this method.

COS: 2

Expanding Access to Contraceptives and Improving Couple Communication about Family Planning In South – West Nigeria: Lessons Learned

John Chukwudi Bako, Uzoamaka R. Okeke, Amaka J. Nneji
Society for Family Health, Nigeria; bakojohnchukwudi@yahoo.com

1. Background/Significance
Contraception is a critical component in the health and well-being of women, their families and communities. Without access to contraception, most women’s ability to participate fully and equally in life is severely curtailed by repeated childbearing and rearing. Limited access to sexuality education, contraceptives, lack of communication between couples about family planning, inadequate reproductive-health services and trained providers have increased the rate of unsafe abortion and maternal mortality in Nigeria. Each year, the failure to meet women’s needs for safe abortion services results in nearly 70,000 deaths and untold injuries to women (WHO, 2003). Women in Africa disproportionately make up 44% of these abortion deaths (WHO, 1998). If these deaths are almost entirely avoidable, the questions then are; how can these unfortunate deaths be prevented? Do Non Governmental organizations have any role to play, if yes what are the roles?

2. Program: State intervention/activity tested
To bridge this gap, Society for Family Health made concerted efforts to increase access to family planning information and contraceptives in Nigeria among female sex workers, uniformed servicemen, transport workers and their spouses. SFH through the PSRHH project (jointly funded by DFID and USAID) distributed and promoted a range of family planning commodities and condoms for HIV/AIDS prevention through commercial sector distribution systems. In 2007, SFH South West Nigeria integrated Family Planning into the organization’s HIV intervention programme for uniform servicemen in Ogun state. The programme targets both the soldiers and their spouses and its mechanism includes advocacy, stakeholders meeting, HIV Counselling and Testing, Couple HIV Counselling and Testing, Referral, community sensitization and mobilization, participatory situation analysis, In-depth Interview, Focus Group Discussions, condom promotion and distribution, training and skill acquisition on contraceptive methods/use.

The programme mobilized and sensitized over 250 soldiers and 242 women on the need to adopt contraceptive methods that provide highly effective protection. It encourages them especially the men to space their children. Those reached were trained on how to use condoms, Cycle Beads and other family planning methods. Both men and women were empowered on how to communicate more about sex with their spouses. Women specifically were thought how to initiate and negotiate condom use or other form of contraceptives with their husbands. Condom use among commercial sex workers and transport workers in SFH intervention sites increased tremendously so is communication between and among couples who were exposure to SFH programs.

Program: State lessons learned
The program revealed that more married women are not interested in having more children. Women are aware of contraceptives as family planning methods but do not know how to communicate the use to their husbands. Women who use effective contraception are much less likely to face an unintended pregnancy. The programme has increased condom availability and accessibility among the target groups that were exposed to SFH programs. Married Men used condoms more than women because majority of them protect themselves while having sexual intercourse with girl friends.

NEXT STEP: The program needs to be scaled up to other communities and more women need to be empowered.

COS: 3

Quality of family planning service in Ethiopia

Abiy Seifu Estifanos, Getnet Mitike Kassit
School of Public Health, Addis Ababa University, Ethiopia; seifu9@gmail.com

Quality of family planning service in Ethiopia

Introduction: Although extending reproductive health (RH) services and improving coverage to the under-privileged and remote areas are often priorities in most developing countries, examining the quality of RH care services delivered is often neglected.

Method: A facility based cross-sectional survey of randomly selected 2258 female of aged 15-49 clients exiting reproductive health service providing facilities were interviewed of which 1,170 were family planning clients. We separately analyzed the quality of family planning as observed by the exit interviewees.
Result: The mean age of the clients was 27.1 ± 6.4 years. The mean time respondents spent to reach the health facilities was 45±64.8 minutes and majority of them (73.8%) would come to the health facility on foot, walking and would wait for 20.5±25.7 minutes to see their service providers. During client-provider contact 900 (76.9%) of the clients were not asked by their providers how many children they want to have and 659 (56.3%) didn’t discuss with their providers about any of the methods in of the family planning clients. Injectables and OCPs were reported to be the most common methods used by the clients, 942 (82.1%) and 161 (14.0%), respectively. In majority of the cases (775, 67.6%) providers informed clients where to get refill of the method but only 370 (32.3%) were informed about the side effects of the method. The study also found that it is not uncommon for providers to choose the family planning method that clients should use (440, 38.4%) and providers decided what method clients should use much frequently in case of clients who took OCP (54.0%) than clients who took Injectables (34.8%). Concerning family planning and STI/HIV/AIDS linkage only 165 (14.1%) and 218 (18.6%) of clients reported that providers did discuss with them on STIs and HIV/AIDS, respectively. With regard to treatment of clients by staffs of the health care establishments 670 (57.3%) and 428 (36.6%) of the clients reported that providers treated them politely and very politely, respectively. Of the total clients interviewed 1,127 (96.3%) of them reported that they were told when to return to the health facility but only 19 (1.6%) were provided with materials to read at home. Overall, 631 (54.0%) and 457 (40.6%) of the clients reported that they were satisfied and very satisfied with the family planning service they were provided, respectively.

Conclusion and recommendation: Although family planning clients in the study area reported being satisfied by the services they have received the waiting time, counseling, method mix and linkage of family planning method with STI/HIV/AIDS were all poor. Training of providers and strengthening supportive supervision at all levels could help in improving the quality of family planning services in the facilities.

C05: 4
Assessing the need of a family planning component in the safe motherhood project in Western Uganda
Richard Semujju, Christine Namayanja
Marie Stopes Uganda, Uganda; semurich@gmail.com
1. Background/Significance
Marie Stopes Uganda with funding from Global Partnership on Output- Based Aid (GPOBA) and Kreditanstalt fur Wiederaufbau (KFW) in partnership with the Ministry of Health, Republic of Uganda has since January 2009 been implementing a safe motherhood project “Healthy Baby” in Western Ugandan districts of Rakai, Lyantonde, Ssembabule, Mbarara, Kiruhura, Ibanda, Isingiro, Ntungamo, Bushenyi, Kamwenge, Kyenjojo, Fortportal, (Kabarole), Rukungiri, Kabale, kasese, Kanungu, Kibale, and Hoima. The target population in this area is 4.5 million inhabitants.

The overall objective of the project is to reduce the number of mothers and children dying or being disabled due to absence or under-utilization of skilled medical attendance during pregnancy and child delivery through the introduction of a voucher system. In this system, a patient gets a voucher at 3,000= to access subsidized medical care at an accredited health facility. The accreditation is based on the Ministry of Health guidelines and standards. The services include Antenatal care, Safe Delivery and Emergency Obstetric Care (EmOC). The service providers then return the vouchers to Marie Stopes for vetting after the client has accessed the services. After vetting the process to ensure that the clients received the services as agreed, the providers are reimbursed to a maximum of US$140 by Marie Stopes who are Voucher Management Agency.

This program has increased poor women’s access to trained medical professionals throughout their pregnancy in Western Uganda. Todate, up to 740 expectant mothers have benefited from the GPOBA’s intervention. A multi-country report by the World bank in 2003 showed that contraceptive use reduces maternal mortality and improves women’s health by preventing high risk pregnancies. However, the Healthy Baby project currently does not have a family planning component. Hence, it is imperative to do a study to assess the need of family planning component on the project. A study to be done before August of this year intends to obtain evidence to support the above-mentioned need.

3. Methodology (including location, setting, period, analysis approach)
The study will use the MSI-UK log frame toolkit guidelines for the Family planning needs assessment. The data collection methods will include exit interviews with safe motherhood voucher clients as they come to access vouchers at the various distribution points, then facility based exit interviews with mothers who have accessed services by use of the voucher. Provider interviews will also be done and Focus Group Discussion with the clients and communities leaving near the facilities. Secondary information from DHS 2006 and other studies will also be used. The quantitative data will be analyzed using both univariate and bivariate analysis, while qualitative data will be analyzed using the thematic and content analysis.

5. Findings
The variables to be investigated in this study will include
- clients’ Knowledge of FP
- Attitude of FP, Use of FP methods
- Unmet need for FP
- Provider of FP methods (or other health)
- Attitude of FP provider (or other health)
- Cost of FP (or other health)
- Service provider user profile (who and why use)
- Non-users of service provider
- Services not available, Barriers to use of FP
- Acceptable cost
- Strengths (quality, supply, reputation, provider attitude, etc)
- Weaknesses (quality, supply, reputation, provider attitude, etc)
- Convenient locations (why, who lives there, good transport)

The discussion of the findings will be based on the interplay of the above variables to highlight the issues related to family planning among safe motherhood voucher clients.

6. Research: State knowledge contribution
It is expected that the findings from this study will help provide a clear understanding of the voucher clients’ intentions for future use of FP methods (unmet need). It will also help the programme implementers understand the dynamics related to having family planning services provided alongside the safe motherhood, potentially using the same voucher distributors, health facilities and providers. Finally, it is expected that the research will present a case for a new financing discipline using the innovative Output Based Aid funding approach that has so far been used successfully on STI and Safemotherhood project in Western Uganda.

C05: 5

Piloting and Sustaining Post Partum IUD Services in Zambia

Josselyn Neukom1, Jolly Chilambwe2, Nomsa Siamwanza2

1Population Services International; 2Society for Family Health, Zambia; josselynneukom@msn.com

BACKGROUND:
The total fertility rate in Zambia is estimated at 6.2 (7.5 in rural areas.) Less than 1% of all married women in Zambia currently use an IUD. Despite evidence of latent demand, access to IUD and other family planning services remains limited. In February 2009, Society for Family Health (SFH)—Population Services International’s (PSI) affiliate in Zambia—expanded its IUD service delivery program to include post-partum IUD (PPIUD) insertion services. Prior to this point, PPIUD services were not available in Zambia.

INTERVENTION TESTED:
Sustaining PPIUD Services in Zambia.

METHODOLOGY:
Advance advocacy among government officials as well as administrators and providers at the University Teaching Hospital and selected government health centres in Lusaka generated support for Zambia’s first post-partum IUD training in February 2009. During the three months preceding the training, SFH met with administrators, managers and influential providers (e.g., “Sisters in Charge” of Labor as well as Maternal, Child Health/MCH divisions) at 3 high volume health centres in Lusaka as well as the University Teaching Hospital. During these meetings, SFH emphasized the safety of the PPIUD procedure and explained how post partum services could expand family planning options for Zambian women. SFH’s previous success increasing uptake of interval IUDs at the same sites had a positive impact on PPIUD advocacy efforts.

In February 2009, SFH trained 2 doctors and 9 midwives in PPIUD procedures during a one-week competency-based course. Some of the midwives who participated in the training had minimal previous experience with IUDs. To ensure competency, SFH required each participant to complete a 5 day competency-based training and to successfully insert at least 20 IUD clients under clinical supervision. By conducting sensitization talks among antenatal clients, SFH identified more than 50 consenting PPIUD clients before the training began. As a result, by the end of the five-day training, 11 providers had demonstrated competency on a pelvic model and 9 clients had been inserted. Supervised practical insertions continued the following two weeks.

Subsequent to the training, midwives offered PPIUD services routinely at three busy urban clinics as well as at the University Teaching Hospital. Trained PPIUD providers generated informed demand for post partum services by conducting daily sensitization talks for women waiting for antenatal check-ups. During these talks, providers discussed side effects as well as benefits associated with PPIUD (including the convenience and relative lack of discomfort associated with this method compared to interval insertions.) Antenatal clients who express a desire to receive PPIUD services are asked to sign informed and voluntary consent forms. A copy of the signed PPIUD consent form is subsequently filed with the labor ward.

PPIUD providers check in with midwives staffing the labor wards on a daily basis to ensure they are notified of all clients requesting PPIUD services. Low-literacy signs advertising “post-delivery loop available here: ask your midwife for more information” were posted prominently throughout labor wards to trigger clients to ask for more information about the service. These three, interlinked demand creation efforts have successfully led to the sustained uptake of PPIUD services at the participating health clinics.

FINDINGS:
Uptake of PPIUD services was significant. Between February and May 2009 (during the first four months following the training), more than 285 clients received post partum IUDs at participating health facilities. This represents a sustained average of 71 monthly PPIUD clients seen since the program began, with the majority of all clients being seen at 2 participating health facilities.

LESSONS LEARNED:
Advocacy with government officials and health providers, competent and committed PPIUD providers at high volume clinics, PPIUD counseling for antenatal clients, and post-training support for PPIUD providers can increase the acceptability and uptake of post partum IUD services.

E05: Men and Family Planning I

Time: Tuesday, 17 November 2009: 9:30am - 11:00am

E05: 1

Is That a Vasectomy in Your Pocket?

Isaiah Ndong, Grace Lusiola, Fredrick Ndeke, Nicholas Kanlisi, John M. Plie, Erin K. McGinn, A. Jensen

EngenderHealth, United States of America; emcgin@engenderhealth.org

1. Background/Significance

Vasectomy is extremely safe, effective, simple, and low-cost, yet on a global scale, it remains one of the least known and least used methods of contraception. By comparison, female sterilization is the most widely used contraceptive method; it accounts for nearly half of all contraceptive use, whereas a mere three percent of married women (15-49) rely on their partner’s vasectomy for contraception.

The use of vasectomy in the world varies significantly by region and country. Prevalence of vasectomy ranges from 10 to 19 percent in eight countries—United States, Great Britain, the Republic of Korea, New Zealand, the Netherlands, Canada, and Australia. In most developed countries, fewer than 5 percent of couples rely on vasectomy, and in less developed countries, the overall prevalence of vasectomy is 2.5 percent. In sub-Saharan Africa (SSA), vasectomy barely registers at a population level; its use is between zero and 0.1 percent, except in Southern Africa, where it is as high as 0.7% in South Africa, and 0.8% in Namibia.

There is demonstrated demand for limiting pregnancies in Africa, along with a greater acceptance of female sterilization. The continued unmet need for limiting and the growing population of women/couples of reproductive age, both suggest that vasectomy should receive more attention in the future. No-scalpel
Contraceptive services can be provided in a variety of settings, including at the primary-care level, thus increasing cost-effectiveness and improving access. Research on costs per CYP shows that vasectomy is significantly less costly than hormonal methods, condoms, and female sterilization. Vasectomy also encourages and enables male involvement and responsibility in meeting couples’ reproductive intentions. Since family planning programs have recognized the need to engage men, and almost one in ten couples in Africa indicate an unmet need for limiting future pregnancies, is there a role for vasectomy in family planning programs in Africa?

2. Research: State main question/hypothesis
Program: State intervention/activity tested

Many in the FP/RH field have suggested that vasectomy is unacceptable to most African men and probably will long remain so. However, similar predictions in the early 1980s that men in Latin America would not accept vasectomy proved unfounded. Through small-scale research and programmatic interventions, there is some documentation that pockets of vasectomy use exist in Africa. What needs to be in place for men to choose vasectomy, and can or should investments be made to scale up vasectomy in Africa?

3. Methodology (including location, setting, period, analysis approach)

This presentation will review existing data and program experience on vasectomy use in SSA over the past two decades. Formative research from Kenya, Ghana, Ethiopia, Tanzania, Uganda, and other countries, provides valuable insight into perceptions of and barriers to vasectomy. Some service delivery program data indicates pockets of vasectomy use—in Kigoma region, Tanzania, and Central Region, Uganda, vasectomy prevalence is 0.6 percent, in Western Cape, South Africa, 1.9 percent, and Erongo Region, Namibia, 2.7 percent. This presentation will also highlight programmatic interventions undertaken by EngenderHealth and partners in rural Tanzania, and urban settings in Kenya and Ghana. This presentation will conclude with suggested areas for further programmatic research, and points for discussion regarding programmatic investments.

4. Data (if relevant)

5. Findings

Existing research on vasectomy in SSA shows a significantly lower level of knowledge and understanding about vasectomy compared to other family planning methods. Barriers to vasectomy use include provider attitudes and lack of services, in addition to client knowledge. Formative research suggests there is an interest in vasectomy among African men, and service statistics from organizations such as Marie Stopes indicate vasectomy procedures can be around 5 percent of client load in the private/NGO sector – significantly higher than the national level. Based on lessons learned from previous experience in Africa and Latin America, EngenderHealth undertook a holistic program intervention in Accra and Kumasi, Ghana; it directly led to a four-fold increase in vasectomy acceptors from the previous year, and the mass media campaign doubled the number of men aware of vasectomy in the urban areas. Programmatic experience shows that when services are provided and misconceptions addressed, African men will accept vasectomy.

6. Research: State knowledge contribution
Program: State lessons learned

With a significant unmet need for limiting future pregnancies in several African countries (Kenya (10%), Rwanda (13%), Uganda (16%), and Benin (19%), and an increasing emphasis on male engagement and involvement in family planning, this presentation will provide participants with an overview of Vasectomy in SSA, as well as suggestions for practical approaches to incorporating Vasectomy into family planning programs.

E05: 2

Husband’s influence over use of modern family planning, in rural Ethiopia

Annabel Erulkar
Population Council, Ethiopia; aerulkar@popcouncil.org

Background/Significance

Many studies of family planning focus on the characteristics of individual users, rather than social factors that may influence use or non-use of family planning. Contraceptive prevalence rate (CPR) is low in Ethiopia, with CPR estimated at 15 percent, nationally. In rural areas where 85 percent of country resides, CPR is an estimated 11 percent (CSA, 2005). In traditional rural settings of Ethiopia, husbands exert considerable influence over decisions in the family. Yet few studies have explored the role of husbands in use or non-use of family planning.

Research hypothesis

This paper investigates the role of husbands in decision making related to family planning. Investigators hypothesize that, in traditional settings such as rural Ethiopia, characteristics and attitudes of husbands are as influential, or more influential, than those of his wife.

Methodology

Data for this paper are from a population based study of women in rural Amhara Region in Ethiopia, which formed the baseline survey for a women’s empowerment intervention. All households in the study area were listed and all households with resident females aged 10 to 45 were considered eligible for study. Eligible households were entered into the computer and selected at random. Where there was more than one eligible female in the household, a Kish grid was used to select one respondent. Selected respondents were interviewed by female interviewers using a largely close-ended instrument that covered a range of issues including education, livelihoods, marriage, family planning use, and safe motherhood issues. Descriptive statistics and multivariate models are used to predict currently married women using family planning methods. Women’s characteristics as well as those of their husbands are included in the models.

Data

This is a population based study of girls and women aged 10 to 45. In all, 3,580 women were sampled and 3,223 were interviewed, reflecting a 90 percent response rate. The subsample of 2,065 currently married women were included in the analysis.

Findings

Median age at marriage among women in the sample was low, 14.9 years, which is consistent with estimates from the Ethiopia DHS (2005). Given the very early age at marriage, virtually all births occurred within the context of marriage (99 percent). Fifteen percent of married women were currently using a family planning method, with 90 percent of users on injectables. Among women who want no more children, 22 percent were using a family planning method.
Multivariate models were used to predict modern family planning use among married women who want no more children. The women's age, education and socio-economic status were included in the model. In addition, characteristics of the husband were included, as reported by respondents. These were husband's education, husband's approval of family planning, and an indicator of violence: having been beaten by the husband in the last year.

Characteristics of the husband seemed to have more influence over family planning use than did women's characteristics. Age of the woman, husband's education, and husband's approval of family planning were all significantly associated with use of a modern family planning methods. Older women were less likely to use family planning; with every successive year of age, women were 10 percent less likely to use family planning. While women's education was not significant in the model, husband's education was. With every additional year of the husband's education, women were 12 percent more likely to use family planning. The strongest predictor of family planning was husband's approval of family planning. Women whose husbands approved of family planning were nearly 4 times more likely to be using family planning then women whose husbands did not approve (OR = 3.9; p<.000).

Knowledge contribution

In traditional rural areas of Ethiopia, men hold considerable influence over family dynamics, including the decision to use family planning. This study demonstrates that attitudes of husbands are extremely influential in family planning decision-making, possibly more influential than characteristics of the woman. Additional efforts are needed to engage men in programs related to reproductive health and health of the family.

E05: 3

Knowledge and current use of family planning service among males in the Ga East Municipality, Ghana

Peter Agyei-Baffour, Selina Ababio, Easmon Otupiri

Kwame Nkrumah University of Science and Technology, Ghana; ayeibaffour@yahoo.co.uk

Background/significance

In Ghana knowledge of contraception is higher among males than females however, usage is low. Giving the crucial role that African men play in family decisions, their support and use of family planning services are critical in family planning programme implementation.

Hypothesis or Intervention/Activity Tested

Knowledge level has influence on current usage of family planning services among men.

Methodology

A cross sectional study was conducted to assess the knowledge level and current use of family planning services among males, in the Ga East Municipality, Accra, Ghana from May to September, 2008. Structured questionnaires were administered to randomly selected 120 men within age 19-59 years and permanent resident in the district. A binary logistic regression was used to predict one’s knowledge of family planning based on his/her age, marital status, educational background, occupation, religion, number of children he has, any effect of distance on utilization of family planning services, any effect of ability to get to the facility on utilization, means of access to the facility, availability of family planning service when needed, and whether one has ever used the family planning service. The classification of variables indicates that about 88% of the variability in the dependent variable (idea about family planning) is explained by the independent variables indicating that the module is very good for prediction.

Findings

Only educational background was a significant predictor (p=0.052) of men’s of family planning, at 90% confidence level. All the other independent variables were not predictors of men’s knowledge of family planning. Thus, as per the first model, for every one level increase in education, the odds of knowing family planning (against not knowing family planning) decreases by 1.281. This could also go to imply that people with higher levels of education appear to have very little interest in issues related to family planning and vice versa.

In the second module, binary logistic regression to predict one’s current use of family planning services based on his characteristics mentioned earlier (age, marital status, educational background, occupation, etc) the classification of variables indicates that about 81% of the variability in the dependent variable (current use of family planning services) is explained by the independent variables.

However, in model 2, compared to model 1 where only educational background was a significant predictor (p=0.052) of men’s knowledge of family planning, at 95% confidence level, marital status (p=0.053 at 95% confidence level), availability of family planning services when needed (p=0.021 at 95% confidence level) and men’s ever use of family planning services (p=0.000 at 95% confidence level) were the only significant predictors of men’s current use of family planning service.

Therefore, as per model 2, given that marital status was coded as single, married, divorced/separated and widowed, in that increasing order, for every one level increase in a person’s marital status, the odds of currently using family planning services (against not using family planning services) decreases by 1.145 units, all other independent variables held constant. This could imply that as people get married and later on in life, they get widowed or reach menopausal stage and are unlikely to use family planning services.

Also, as men have one more child, they make one more use of family planning services and vice versa. This implies that the higher the parity of men, other factors held constant, the more they utilize family planning services. Likewise, as family planning services are available, men are likely to make three times use of the services and vice versa, all other independent variables held constant. This also explains the fact that men’s utilization of family planning services, to a large extent, is engendered by the availability of family planning services. Finally, if a man one has ever used a family planning service, he is about four times more likely to use it again, and vice versa, all other factors held constant. This also clearly explains that persons who have ever utilized family services are four times more likely to use it again. Hence, the challenge faced by family planning providers is how to get people to utilize family planning service for the first time. The moment they are committed to utilizing such services for the first time, people are more likely to go on utilizing them on their own.

Knowledge Contribution or Lessons Learned

In conclusion educational background is a significant predictor of men’s knowledge about family planning. But interestingly, men with higher level of education and knowledge appear to have very little interest in the use and other issues related to family planning. There is a significant relationship between the intention of men to have more children and knowledge about family planning. These findings have implications on designing interventions to improve utilization of family planning among men.

E05: 4

Male Involvement in Family Planning Decision Making in Ile-Ife, Osun State

Macellina Yinyinade Ijadunola1, Kayode Thadius Ijadunola2, Adepeju Esimai2, Titilayo Collette Abiona2, Olasegun Temitope Afolabi2

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Background: This study assessed men’s knowledge, attitude and practice of modern contraceptive methods, determined the level of spousal communication about family planning decision making, and examined the attitudes of family planning providers towards male participation in reproductive health services.

Activity: The aim was to determine the extent of male involvement in family planning and reproductive goal decision making among couples in Ille-Ife, Nigeria.

Methodology: Both quantitative and qualitative methodologies were used. The quantitative survey employed a cross-sectional descriptive design using a structured household questionnaire to collect information from 402 male study participants and 50% of their spouses. A multistage sampling procedure was employed, where 10% of the 400 enumeration areas (EAs) were selected by simple random sampling. For the selected EAs, all the constituent households (second stage sampling unit) were listed and one eligible respondent (third stage sampling unit) was interviewed from every Kth household. The qualitative design consisted of twelve focus group discussions and four in-depth interviews with identified groups and individuals. Data were analysed using appropriate descriptive and inferential statistical techniques.

Findings: A majority (72%) of the male respondents were aged between 30 and 49 years, while half of the female respondents were between 30 and 39 years old. Virtually all (99.8%) male respondents were aware of the existence of at least one modern family planning method. Eighty nine percent of men approved of the use of family planning while only about 11% disapproved of it. The most common reason given for family planning approval was birth spacing, while that for disapproval was religious dictates (44%) and 38% respectively. Eighty percent of men had ever used contraception while 56% of them were current users. Spousal communication about family planning and other family reproductive goals was quite poor, as consistently less than a quarter of either male respondents or their spouses individually discussed issues on common reproductive health issues such as when to achieve a pregnancy, when to avoid a pregnancy and use of contraceptives. Furthermore, about a third of couples never discussed family planning in the year preceding the survey, while just about half of men and two-fifths of their spouses discussed family planning only one or two times during the same time period. While most of the female focus group discussion participants had attended family planning clinics, mostly male participants had not. All family planning providers interviewed corroborated men’s low patronage of family planning services, but were favorably disposed to men attending their services. The providers were of the opinion that cultural beliefs, societal perception that family planning was a women’s affair and religious misconceptions were the main reasons for men’s poor patronage.

The study concluded that male involvement in family planning decision making in Ille-Ife is poor and their patronage of family planning services is low.

Lesson Learned: Based on the findings of this study, the following recommendations are made:

- There is a need for more male targeted information in the mass media. Since the electronic media was the most popular source of family planning information among study participants, it is recommended that more enlightenment campaigns target at men should be mounted on the radio and television networks.
- Need to build partnerships. A significant proportion of study participants also reported obtaining their family planning information from friends and relatives, while others cited religious beliefs and dictates for their practices. There is therefore an urgent need to build partnerships with the religious organizations and civil society groups in order to effect a lasting change in attitudes and practices of men concerning family planning.
- Hiring of male service providers. Training and employment of more men as family planning service providers may help to address the stereotypes and misconceptions of men and the society that family planning services are strict concerns of women.
- Improved social marketing of family planning commodities. Commercial sales outlets have long been men’s chief source of condoms. To make supplies more accessible and least restrictive to partners, there is a need to establish more social marketing program that sell contraceptives at subsidized prices through established commercial outlets so that men can buy social-marketed condoms and other commodities.
- Community-based resource persons. Community-based resource persons trained in key household and community practices that impact on the health of household members may also be trained as family planning motivators and distributors who can provide men and women with necessary information and services for enhanced spousal communication and commitment to family planning.

E05: 5

Psychosocial Support during Childbirth as a Catalyst for Modern Family Planning uptake in Nigeria: a Randomised Controlled Trial

Oladosu Ojenbede1,2, Imran O. Morhason-Bello3, Babatunde O. Adekunle4, Stan Becker5, Gbolahan Oni6, Amy Tsui7

1Department of Obstetrics and Gynaecology, University College Hospital/College of Medicine, Ibadan, Nigeria; 2Department of Epidemiology, Medical Statistics, and Environmental Health, College of Medicine, University of Ibadan; 3Gates Institute, Bloomberg School of Public Health, Johns Hopkins University; 4Centre for Population and Reproductive Health, College of Medicine, University of Ibadan; ladosu2002@yahoo.co.uk

Background: The quality of maternal health is one of the key indicators of human development index of any country, and it is often evaluated by use of maternal mortality ratio. Family planning uptake has remained the foremost and cheap strategy to reducing MMR globally but, its implementation in developing countries has not received the much desired successes including Nigeria. Although, modern FP uptake in Nigeria has marginally increased from 13.0% to 15.0%, however, this achievement is far cry from ideal. Positive disposition of Nigerian fathers towards supporting their spouse during childbirth have been reported but, the implication of such assistance on other reproductive health issues including FP uptake is yet to be explored. We therefore hypothesized that presence and support by Nigerian fathers to their spouse during childbirth could improve their uptake of modern FP.

Material and Method: A Randomized Control Trial was performed to investigate the effect of husbands’ presence as support persons in labour on intention to use modern contraceptive after delivery at the University College Hospital, Ibadan, Nigeria from February 2008 till May 2009. The women were also followed up for six months after delivery. Repeated measurements of intention to use modern contraceptive at delivery, person initiating use and contraceptive methods used at 6 weeks and 3months were taken from the women. Analysis was by intention to treat. Comparison between groups was tested using the Chi square test and logistic regression for multivariable analysis. The statistical significance was at 95% confidence level.

Results: The result of 402 women – 201 in experimental and 201 in control groups. The two groups were comparable, with no statistically significant difference concerning age, family type; education, number of living children, number of male children, religion, ethnicity and previous contraceptive use. At delivery women who had support were more likely to desire next pregnancy at a later date than controls (OR = 1.68, 95% CI = 1.04 – 2.72) but no significant difference in desire to use modern contraceptive after delivery. However women in the experimental group appeared to use contraceptives more with time: they were more likely at 6 weeks (OR = 2.84, 95% CI = 1.81 – 4.84) and at 3 months (OR = 7.94, 95% CI = 3.86 – 16.39) to be current users of modern contraceptives compared to controls. Husbands were also more likely to initiate the use of modern contraceptive among women in the experimental group compared to controls (OR= 2.36, 95% CI OR = 1.37 – 4.05).
Conclusion: This trial reveals that support offered by Nigerian fathers during childbirth may provide a paradigm shift to the appallingly low contraceptive uptake. This strategy of male involvement may provide a new policy direction in other reproductive health

F05: Contraceptive Practice in Asia

| Time: Tuesday, 17 November 2009: 9:30am - 11:00am |

F05: 1

Contraceptive Use is More Equitable than Maternal-Child Care in India: Exploratory Analysis

Ram Faujdar
International Institute for Population Sciences, India; fram@iips.net

BACKGROUND

Family planning program in India was launched in early 1950s and MCH program was integrated with program with keeping greater coordination in providing various services by last point service providers (LPSP) in mind. When LPSP assess the need of community for various reproductive health services and prepare the logistic plan as per needs, equity in utilization of various services may be similar. Or services that are more influenced by individual and community factors will be less equitable. Between two-contraceptives use and maternal - child care second one being directly linked to child survival- regulating fertility i.e. limiting number of children is expected to be influenced by community and individual factors more than the taking care of mother and child health. We strongly perceive therefore that the equity in maternal and child care would be more than that in contraceptives use in developing society. Such process of development may also be supported by diffusion theory i.e. innovative ideas generally get spread from top of social-economic hierarchy of the society to the bottom of the society. Nevertheless, certain innovation move faster with space than other depending on cost and visible dividend.

HYPOTHESIS

1. Contraceptive use should be less equitable than maternal-child care in developing society like in India
2. Accessibility and quality is main factor in determining equity in utilization

METHODOLOGY

Simple bi- variate analysis is used to examine the inequity in contraceptive use and maternal-child care. Gini index and Lorenz curve is used to demonstrate the inequity. Advanced statistical analysis is applied to understand the contributing factors in to three categories- cost (public Vs private), community barriers and household barriers

DATA

Data for the present paper is taken from National Family Health survey conducted during 1992-93, 1998-99 and 2005-06 with sample size of more than 90000 ever married women.

FINDINGS

In order to understand the inequity in case of India and in its state three variables are taken in to consideration- education of women ( No education, < 5 years, 5-7 years, 8-9 years, 10-11 years, 12 or more years), caste of head of household (Scheduled Caste, Scheduled Tribe, Other Backward Class, Others) and wealth quintiles. It has been observed that inequity in contraceptives use by education is not very clear in 2005-06 as nearly 46 per cent of women with no education are using contraceptives whereas as just 51 percent of women with 12 or more years of schooling are using contraceptives. Similar pattern may be seen with respect to castes factor. There are however substantial inequity in use by wealth quintiles. Around 35 per cent of women in lowest quintiles are using contraceptives whereas 58 percent of women in highest quintiles are using contraceptives.

In contrast to inequity in contraceptives, there is very large difference in maternal care like ANC and Institutional deliveries. Only 18 per cent of women with no education delivered their child in institution whereas more than 86 per cent of women with 12 or more years of schooling did so. Similar pattern emerges in case of wealth quintiles- only 13 per cent institutional deliveries among women in lowest and these moves to 84 per cent for women in highest quintiles.

Analysis indicates cost-direct and indirect as major player for observed inequity in maternal-child care Vs contraceptives use in India.

LESSON LEARNED

In order to bridge the gap in maternal and child care across different social and economic groups and thereby higher use of contraceptives there is urgent need to strengthen public sector facility. Janani Surkha Yojana (Conditional Cash Transfer Program to ensure institutional deliveries) for all women in poor performing states of India is good steps in this direction

F05: 2

Contraceptive Use Pattern among Married Women in Indonesia

Ria Rahayu1, Iwu Utomo2, Peter McDonald2

1Indonesia National Family Planning Coordinating Board (BKKBN), Indonesia; 2Australian Demographic and Social Research Institute (ADSR), The Australian National University (ANU); riayu_80@yahoo.co.id

1. Background

For almost 40 years fertility in Indonesia has declined steadily. The total fertility rate (TFR) declined from 5.6 children per woman in 1967-1970 to 2.6 children per woman in 2007. Much of the decline is due to an increase in the contraceptive prevalence rate (CPR) from 18% in 1976 to 61% in 2007. This reflects the success of the national family planning program in Indonesia implemented by the National Family Planning Coordinating Board (BKKBN). However, the policy of decentralization has brought fundamental changes to family planning program management since it was officially implemented in 2004. With decentralization, the BKKBN no longer has authority over regional governments because they have their own authority and right to make policies autonomously and to organize their budgets independently. The BKKBN cannot simply order local governments to increase their family planning’s budgets. Furthermore, the decentralized government structure provides challenges for BKKBN in promoting family planning programs where they have stagnated. Commitment and support by regional governments for the family planning program varies depending on their perceptions of the importance of the program for their district. In 1997 (before decentralization), the contraceptive prevalence rate (CPR) was 57.4 percent and in 2007 (after decentralization) it was 61.4 percent. Over a ten-year period, the CPR has increased by only 4 percent. This suggests a relatively weak performance of the family planning program in Indonesia after decentralization, even though the knowledge of contraception is high among married women.
2. Main Question
This study examines whether the contraceptive use pattern in Indonesia has changed between 1997 (before decentralization) and 2007 (after three years of the decentralization) by analysing the demographic and socio-economic factors influencing contraceptive use before and after decentralization.

3. Methodology
Bivariate and multivariate analyses are used to examine the pattern of contraceptive use, where logistic regression analysis is applied to identify associations between contraceptive use and selected demographic and socio-economic characteristics.

4. Data
The data are obtained from the 1997 and the 2007 Indonesia Demographic and Health Survey (IDHS) with 26,886 married women as respondent in 1997 and 30,931 married women in 2007.

5. Findings
The results show that almost the selected characteristics have a significant relationship with contraceptive use in both years. Women's age, residence, number of living children, women's education, religion, desire for more children, visited by family planning worker, and husband's view on family planning had significant relationships with modern method use. Interestingly, the number of living children, religion, and the husband's view on family planning no longer had a significant relationship when only long-term method use was considered. The results indicate that women's education is one of the most important factors related to contraceptive use in both years. Meanwhile, being visited by family planning worker had a significant impact on contraceptive use before decentralization but it was no longer significant after decentralization, even though it still had a positive effect.

6. Knowledge Contribution
The trend in the rate of contraceptive use over the ten-year period suggests the stagnation of the family planning program. The results of this study highlight the effects of the relaxation of the family planning program in Indonesia after decentralization. This suggest that the challenge for the government of Indonesia is to promote family planning by giving better information, supply, access and services about family planning as well as reproductive health, especially in rural areas. It is important that both national and local governments view fertility control programs through family planning as an integral part of an effective poverty alleviation program by increasing welfare through a small family norm. Strategies that make family planning services available, affordable and accessible for all people with a wider range of contraceptive methods will have the greatest impact on increasing contraceptive use. In addition, it is essential to promote long-term methods of contraception. Raising levels of education, improving employment opportunities for women, and encouraging males to participate in family planning are an effective means of advancing family planning acceptance and increase the prevalence of contraception. Moreover, it is also important to increase the number of family planning workers as they contribute to the success of family planning in Indonesia.

FOS: 3

Contraceptive Use and Method Choice in Urban Slum of Bangladesh
S. M. Mostafa Kamal
Islamic University, Kushizia-7003, Bangladesh; kamaliubd@yahoo.com

1. Background/Significance
Bangladesh has experienced dramatic increase of contraceptive use and a sensational decline in fertility over the last three decades. The fertility has decreased from 6.3 births in the mid-1970s to 2.7 births per woman in 2007 and contraceptive use rate has increased more than three folds during this period from 7.7% to 55.8%. This progress in Bangladesh is viewed as the “success in a challenging environment”. Despite, the recent recommended policy by the donors and development partners regarding field worker’s duties to focus on motivating nonusers to adopt contraceptive rather than supplying non-clinical methods, suggests the need to understand factors affecting contraceptive use, method choice and willingness to pay among the poor.

2. Hypothesis/activity tested
The study aims to investigate the factors affecting contraceptive use and method choice among women living in the urban slums in Bangladesh. It also aims to examine the source of modern method collection among them. It has been hypothesized that contraceptive use and method choice varies significantly among subgroups of slum dwellers by socioeconomic and demographic factors.

3. Methodology
The study dealt with a weighted sample of 5160 currently married women of reproductive age living in the slums extracting data from the nationally representative 2006 Bangladesh Urban Health Survey (BUHS). Both quantitative and qualitative statistics have been used to examine the association and effects of various socioeconomic and demographic factors on current contraceptive use and method choice. To investigate the factors affecting contraceptive use we applied binary logistic regression, while multivariate multinomial logistic regression analysis has been applied to estimate the risk of traditional and modern method choice. The results of logistic regression analyses have been presented by odds ratio (OR) with 95% Confidence Interval (CI). The statistical analyses have been performed by SPSS 11.5 software.

4. Data
The study used 2006 BUHS data. The 2006 BUHS followed multistage sampling procedure to collect data from slum, non-slum and district municipalities. To meet the objectives, the present study is confined with eligible women from slum domain only. The survey obtained information concerning urban health issues including reproduction, fertility, family planning, child nutrition, chronic diseases, drug abuse, mental health etc. Such a large data set provided a unique opportunity to study the contraceptive use and method choice among slum dwellers in Bangladesh.

5. Findings
The contraceptive prevalence rate among women living in the slum was found to be 58.1%; included 53.2% modern and 4.9% traditional methods. The most preferred modern method was the pill (29.0%), followed by injections (14.4%), female sterilization (3.6%) and condom (3.4%). Periodic abstinence (4.2%) was the most preferred traditional method. More than half of the women (54%) bought non-clinical modern methods from pharmacy or shop. The both bivariate and multivariate analyses identified several variables as important determinants of contraceptive use such as, women’s education, watching TV, number of unions, women’s work status, wealth index, NGO membership, number of living children and child mortality. The multivariate multinomial logistic regression analysis yielded significantly (p<0.001) increased risks of modern method preference among women aged 25-34 (OR=2.52; CI=2.12, 2.99), women with primary education (OR=1.56; CI=1.36, 1.83), who usually watch TV (OR=1.51; CI=1.26, 1.80), NGO members (OR=1.27; CI=1.09, 1.49), working women (OR=1.23; CI=1.08, 1.41), women with living children two to three (OR=3.64, CI=3.08, 4.31) and who were middle class in terms of wealth index (OR=1.54, CI=1.09, 2.17); and
decreased risk of modern method use among women married twice or more (OR=0.51; CI=0.37, 0.70), experienced child death twice or more (OR=0.69, CI=0.53, 0.88). The risk of traditional method use was significantly (p<0.001) higher among women with at least secondary education (OR=1.64; CI=1.10, 2.44), who watch TV regularly (OR=2.24; CI=1.43, 3.52) and working women (OR=3.50; CI=2.13, 5.75). Mass media exposure appeared as the most single significant socioeconomic determinant of contraceptive use and method choice among slum dwellers.

6. Knowledge contribution or lessons learned
The findings reveal higher level of contraceptive use among slum dwellers in Bangladesh. In addition to a range of socio-demographic variables mass media exposure, NGO membership and experience of child mortality were found to be highly statistically associated with contraceptive use and method choice. The NGOs could play more positive role in motivating their clients for permanent method use. Mass media could play more effective role to inspire couples to use modern methods highlighting the benefits of smaller family. Increased efforts should be made to provide the poor long-term effective method through community clinics. Although the urban poor are willing to pay, door-step delivery services of modern contraceptive methods should be continued by family planning workers to raise more the use rate of modern methods.

FOS: 4

Evidence based decision making for increasing current use of oral contraceptive pills and condoms in the rural areas of Jharkhand, India.

Amajit Mukherjee1, Dan Rosen2
1Population Services International, Gurgaon, India; 2Population Services International, Washington DC, USA; amajit@psi.org.in

1.0 BACKGROUND
Population Services International implemented a birth spacing communication campaign from April 2006 to March 2008 in five districts of the state of Jharkhand, India. Jharkhand is one of the least developed states of India with a crude birth rate of 32.8 and a TFR of 3.3. The IMR for Jharkhand stands at 69 (NFHS-3 estimate). The purpose of this program was to promote the continued use of condoms and pills (OCP) to space births among married non sterilized men and women of reproductive age (males 21-34 years, females 15-29 years).

2.0 RESEARCH HYPOTHESIS

We investigated the determinants of current use of OCP and condoms in rural and low literacy settings of Jharkhand, India. We also examined change in behaviour depending on the level of message exposure.

3.0 METHODOLOGY

Cross sectional surveys among eligible respondents (male and female) were conducted in November 2005 and June 2008 from a sample of villages units in the program districts. Stratified two stage cluster sampling was done wherein district comprised the strata and village units were defined as the primary sampling units (PSU). The desired sample size (2020) was calculated for project to allow comparison over time between independent samples: significance level was set at 0.05 and power was set at 80%. The baseline survey identified the key determinants of promoted behaviour. Logistic regression was used to examine relationships between the determinants and current use of OCP or condom. Determinants related to behaviour of interest were classified according to framework of opportunity, ability and motivation (Rothschild 1999). During the end line survey adjusted proportions and means were generated to check whether the behavioural indicator and its determinants changed significantly from baseline, and whether such change was associated with program exposure as measured in end line.

4.0 FINDINGS

The baseline research allowed programmers to identify the significant determinants of promoted behaviour. Perceived availability of OCP or condom (odds ratio=1.10; CI=1.085 – 1.240), self efficacy to use such contraceptives (odds ratio=1.76; CI=1.418 – 2.195) and positive social support from spouse for using the same (odds ratio=1.51; CI=1.376 – 1.667) were found to be strongly associated with current use. Subsequently, these determinants were used for identifying the key message areas for communication.

The end line research showed that current use of OCP or condom increased from 12.5% to 19.1% (p<0.05). The mean score for perceived availability increased from 3.24 to 3.64 (p<0.05). The mean score for self efficacy increased from 3.96 to 4.39 (p<0.05) and for social support from spouse increased from 2.02 to 2.54 (p<0.05).

Exposure towards program activities was found to be reasonable with 58.5% survey participants recalled to have seen Nukkad Natak (a form of street play) organized by PSI. The exposure to inter personal communication session was recalled by 37.8% men and 32.1% women. Three fourth (75.7%) of surveyed respondents reported to have seen wall art or wall writing done as a part of program activity.

Effect of program exposure was gauged by grouping the audience into four categories: not exposed, exposed once, exposed 2-5 times and exposed 6-10 times. The end line results showed that current use of OCP or condom was higher (23.7%) among those exposed 6-10 times as compared to those not exposed (16.9%). Mean score for perceived availability was found to be higher among those exposed 6-10 times (4.0) and exposed 2-5 times (3.7) as compared to those not exposed. Mean score for perceived availability, self efficacy and spousal support was found to be significantly higher among those exposed 6-10 times and exposed 2-5 times as compared to those not exposed.

5.0 DISCUSSION AND LESSONS LEARNED

There are several lessons learned from this intervention. Firstly, segmenting the target audience into behaver and non behaver is a useful approach for identifying the triggers of behaviour change. Secondly, repeat exposure to program activity is important for behaviour change among target audience. The exposure measurement clearly showed that behaviour change occurred after at least 6 exposures to program activities. Although a lower level of exposure could change some of the determinants, but it was not sufficient to achieve the desired level of behaviour change. The intervention demonstrated that it is possible to increase current use of OCP or condoms among the target audience and thereby reduce unplanned pregnancy and promote Healthy timing and spacing of pregnancy (HTSP).

Disclaimer: This intervention was funded by the David and Lucile Packard Foundation. The views expressed herein are those of the authors and do not necessarily reflect the official policy or position of the David and Lucile Packard Foundation.

FOS: 5

Innovations for Expanding Contraceptive Use in Rural Afghanistan

Douglas H. Huber1, Nika Saeedi1, Khalil Samadi1, Hadayetullah Mushfiq1, Razia Rahimzai2

1Population Services International, Gurgaon, India; 2Population Services International, Washington DC, USA; amajit@psi.org.in
BACKGROUND/SIGNIFICANCE

Women in post-conflict Afghanistan have one of the world’s highest lifetime risks of maternal death, one in eight. Years of conflict devastated the country’s health infrastructure, total fertility rates remained high, 6.8, contraceptive prevalence rates (CPR) were below 10%, and Afghan models of success for family planning were non-existent. The majority (80%) of the 32.7 million Afghans lived in rural areas and women could not access health services outside their community.

With the new Basic Package of Health Services in 2004, rural Afghanistan had 14,000 community health workers (CHWs), half being women. However, family planning was perceived as culturally sensitive, requiring a slow and cautious approach. CHWs were often reluctant providers.

HYPOTHESIS OR INTERVENTION/ACTIVITY TESTED

Modern contraceptives–pills, injectables, condoms–could be introduced rapidly, combining three key approaches:

- Expertise in contraceptive technology and a new health paradigm comparing contraceptive safety to risks of pregnancy
- In-depth knowledge of couples and communities
- Program innovations that simultaneously engaged community/religious leaders, CHWs, and couples

METHODOLOGY

We selected three rural areas with different ethnic populations—Pashtoons, Hazaras, and a mixed population of Tajiks and Heratis—served by three Afghan NGOs. We conducted community assessments to craft interventions to strengthen rural CHWs’ competence and confidence to deliver contraceptive services to 3708 women, to gain support from community leaders and clinic staff, and to build on the existing USAID/Management Sciences for Health project, Rural Expansion of Afghanistan’s Community-Based Healthcare Program. Contraceptive prevalence data were collected directly from CHW community maps, October 2005 to June 2006, and externally verified by individual household inquiries of users. CHWs initiated the use of injectables for the first time.

We worked closely with communities, focusing on the most common non-harmful side effects of contraceptives and access to injectable contraceptives, pills, and condoms. Regular interaction with community leaders, mullahs, clinicians, CHWs and couples helped ensure ongoing support for culturally acceptable innovations.

Key messages:

- contraceptive use is 300 times safer than pregnancy in Afghanistan
- the Quran promotes two years of breastfeeding; therefore contraceptive use for 18+ months is needed to prevent short pregnancy intervals that cause breastfeeding cessation, high infant/child mortality, and increased maternal morbidity/mortality.

Surveys in 2007/2008 assessed women’s desires for spacing/spacing births.

DATA

The CPR increased 24–27 points over eight months (October 2005 to June 2006) for the three project areas in Ghazni, Herat, and Kabul Provinces—from 24 to 51; 20 to 44; 9 to 34. Method-specific CPR changes for the same sites were: injectables, 7 to 18, 6 to 27, and 2 to 15; oral contraceptives, 9 to 6, 11 to 12, and 5 to 13; condoms, 6 to 25, 1 to 2, and 3 to 4. Method preferences varied widely by site.

Surveys in 2007 and 2008 documented that for women in project areas with a child one year of age or less, about 1/3 to 1/2 wanted no more children; 42–50% wanted to wait one or more years, and only 10–13% wanted to become pregnant in a few months.

FINDINGS

New simplified informational materials cost $0.04 per household to provide guidance on injectables and orals, including quotes from the Holy Quran on birth spacing, covering all 3708 households and providers. Materials were well received, understood and retained. Signs for health posts–the homes of CHWs–cost $1.60 each. CHWs valued the recognition and communities learned the location of services. Replication was easy and cost-efficient.

Ethnic differences did not impede increased contraceptive use. Religious leaders, both Sunni and Shia, supported the health rationale for increased birth spacing using modern contraceptives. Several mullahs explained modern contraceptives to men during Friday prayers. CHWs successfully and safely provided first injections. Women and community leaders warmly welcomed the elimination of previously mandated clinic visits.

Rapid increases in CPR within diverse communities signaled the need for NGOs, the MoPH and donors to plan for higher use of modern contraceptives with flexibility for variable method preference.

CHW performance in treating respiratory infections, diarrhea and malaria also improved—a successful example of integration with child health services without increasing providers.

Men supported modern contraceptives once they understood contraceptive safety, effectiveness, and non-harmful side effects.

Injectables contributed most to overall CPR increases.

KNOWLEDGE CONTRIBUTION OR LESSONS LEARNED

Removing fear and misunderstanding of contraceptives remains crucial for clients, CHWs, clinicians and community leaders. Religious leaders, with dialogue and understanding of contraceptive safety and the importance of birth spacing, will support community birth spacing and modern contraception. None of the 38 local mullahs objected to the accelerated contraceptive program.

Ethnic differences are not an inherent barrier for increasing contraceptive use. Afghanistan’s 14,000 CHWs can substantially increase rural contraceptive use, particularly injectables.

Meeting the needs for long-acting and permanent methods will require new emphasis on clinical methods, such as intrauterine devices (IUDs).

Education that contraceptive use for a year was 300 times safer than pregnancy was highly effective in shifting from pervasive misconceptions about dangers of contraceptives to a focus on improving access and continuation.

CHWs can rapidly increase contraceptive use in rural areas when given responsibility and guidance. The MoPH adopted project innovations as best practices, which are now used for scaling up contraceptive use nation-wide.
G05: Costing and Tracking Funding for FP
Time: Tuesday, 17 November 2009: 9:30am - 11:00am

G05: 1
Re-Costing ICPD: Making the New Numbers Work for Advocacy
Suzanna Dennis, Clive Mutunga
Population Action International, United States of America; sdennis@popact.org
1. Background/Significance
The International Conference on Population and Development (ICPD) in 1994 estimated the financial resource requirements to achieve universal access to a range of population-related programs including family planning and reproductive health. Developing country governments and donors committed to achieving these goals, with donors providing one-third of the necessary financing, and domestic resources making up the other two-thirds. Although funding towards these commitments has fallen short, advocacy groups promoting family planning, reproductive health and rights depend on the estimates particularly to hold donors accountable to fulfill their fair share.
Nearly fifteen years after the ICPD estimates were produced, a consensus developed among technical experts and advocacy groups that the 1994 ICPD cost estimates were out of date. Escalating need, rising drug and supply costs, and the scale of the resources needed to address the HIV/AIDS pandemic undermined the relevance of the original estimates, and therefore their usefulness for advocacy. In response to pressure, UNFPA developed new cost estimates of the minimum resources required to meet the ICPD goals, in consultation with technical expert groups including PAI. In 2009 UNFPA released the updated cost estimates which start at nearly US$50 billion in 2009 and grow to nearly US$70 billion in 2015, roughly double the original ICPD figures. These new estimates were approved by member states of the 2009 Commission on Population and Development.
While the new UNFPA cost estimates an important step towards uncovering the financial obligations needed to meet the ICPD goals, in their current form they are not useful for advocacy. The family planning and maternal health components separate-out health systems and program costs from direct service costs (or staff time and supply costs), thus seemingly underestimating the costs of family planning and maternal health. Donor funding for interventions historically tracked by UNFPA include much more than direct service costs, therefore when donor spending is compared to the direct costs it will give a false impression that donors are funding their share, when in fact, they are not. Even if a portion of the health systems and programs costs are allocated to family planning, the new UNFPA estimate is $10 billion less than the inflation-adjusted original ICPD estimate. Such projections suggest an underestimation, as it is doubtful that family planning costs have gone down given the increase in unmet need for contraception. There are questions whether (and how) the revised UNFPA estimate addresses education, outreach, safe legal abortion, people using traditional methods of family planning, and unmarried women. It is also unclear how the new UNFPA estimate relates to other existing estimates of family planning funding needs, including those computed by the Norwegian Agency for Development Cooperation (2008), Vlassoff and Bernstein (2006), World Health Organization (2005) and others.
2. Main question
The research questions for this paper are: What are the strengths and limitations of the new UNFPA ICPD costing of resource needs for family planning and reproductive health? How can they be made to better reflect advocacy needs? And what are the commonalities and differences between the UNFPA numbers and other cost estimates?
3. Methodology
These questions will be explored through a desk review gathering detailed analysis of the methodology, costed interventions, and assumptions underlying the UNFPA costing and other estimates. The data will be compiled into a table, analyzed, and synthesized into a paper. This research will occur from July to October, 2009.
4. Data
Necessary information will be gathered from documents and supplemented by communications with key actors involved in producing the various cost estimates.
5. Findings
Preliminary analysis suggests that the limitations of the UNFPA costing need to be addressed for the numbers to be useful for advocacy. It is difficult to compare cost estimates because they often vary in scope.
6. Research: State knowledge contribution
The ICPD estimates were clearly out of date, and the UNFPA estimates are a welcome development. However, without guidance and clarification they are not useful for advocacy purposes. This paper will guide the family planning and reproductive health advocacy community on how to effectively use the UNFPA numbers, and unite the global community around one estimate of resource needs.

G05: 2
Donor Commodity Support Required to Scale-Up Family Planning Services in Low- and Middle-Income Countries
John Stover1, Eva Weissman1, John Ross2
1Futures Institute, United States of America; 2Futures Group International; sdennis@popact.org
1. Background/Significance
Donor resources are the major source of support contraceptive supply in almost 90 low- and middle-income countries. This support amounts about $225 million per year and has been relatively constant at that level since 2000.
2. Research Objective
The objective of this study was to determine future levels of donor support for family planning commodities required through 2020 to support achievement of the goals of the Declaration of Commitment of the International Conference on Population and Development (ICPD).
3. Methodology
For each of 88 donor-dependent countries we estimated the contraceptive prevalence rate (CPR) required to achieve the total fertility rate (TFR) projection of either the medium variant of the United Nations Population Division or to meet unmet need by 2020. We developed patterns describing how method mix
changes as prevalence increases based on DHS data and applied these patterns to estimate the changing method mix in each country to 2020. The number of users and acceptors of each method was estimated from the CPR, method mix and number of women of reproductive age. The current donor share of each commodity was calculated by comparing total current estimated consumption with UNFPA data on donor shipments. With this information we produced projections of funding requirements for commodities by commodity, county and region.

4. Data

Estimates of the number of women of reproductive age are taken from the United Nations Population Division. Current levels of the total fertility rate, contraceptive prevalence and method mix are from Demographic and Health Surveys. Donor shipments of family planning commodities by country are from the United Nations Population Fund. Commodity costs are based on current prices paid by UNFPA and USAID.

5. Findings

Table 1 shows projections of the number of contraceptives required over the period of 2005-2020 for each of the six methods provided by the public sector in the 88 countries studied. Data for the long-term methods reflect the supplies required at the time these methods are adopted, as most commodity costs are incurred at that time. In the Unmet Need Scenario the number of sterilizations for both men and women is expected to increase by 73 percent over the next 15 years, increasing from 2.0 million new acceptors in 2005 to 3.5 million in 2020. The number of women adopting the IUD would increase by 71 percent over the same period, from 3.7 to 6.2 million. The number of pill cycles and injectables required would increase by 94 percent and 111 percent, respectively. The demand for condoms is projected to increase by 109 percent to 4.2 billion condoms in 2020 (this includes both condoms used for family planning and HIV/AIDS prevention).

In the past donor funding for commodities has fluctuated substantially from year to year. The trend shows an increase from $79 million in 1990 to nearly $223 million in 2007 (Figure). The average rate of increase has been 6.3 percent per year in current dollars.

As the Figure shows, in the year 2020, an estimated $424 million would be required in commodity support in order to satisfy all demand (prevalence plus current unmet need) for contraceptives in donor-dependent countries. If donor funding were to remain at or around current levels this means funding would fall short by almost $200 million. The cumulative shortfall over the 2008-2020 period would be around $1.4 billion. Even under the more moderate Medium Variant scenario, donor funding would fall $145 million below the required amount in the year 2020 (a cumulative shortfall of more than $800 million). Note that Figure 9 only shows the donor financing for commodities. The total requirement from all sources, including national government financing through domestic revenues and loans is much greater.

6. Knowledge Contribution

In order to meet estimated commodities needs, donor funding will have to increase by almost $200 million to $424 million by 2020 to meet unmet need or by $145 million to $368 million to match the Medium Variant of the UN Population Division projection. The annual growth rate in donor funding required to meet unmet need by 2015 is 7.0 percent, slightly higher than the historical rate of increase. If this goal is achieved the required growth in funding after 2015 would drop to only 2 percent per year.

GO5: 3

Tracking European Donor ODA Funding for RH and RH Supplies: Challenges for Advocacy in a European context

An Huybrechts

International Planned Parenthood Federation - European Network; sdennis@popact.org

1. Background/Significance

We are approaching the 20th anniversary of the International Conference on Population and Development (ICPD) – the landmark 1994 meeting which set out an ambitious 20-year programme for achieving gender equality, eliminating violence against women and ensuring women’s ability to control their own fertility, based on principles of individual needs and rights. Since the ICPD, the United Nations has further recognized the crucial need to improve reproductive health, by adopting a new target under Millennium Development Goal (MDG) 5 for achieving universal access to reproductive health by 2015.

Unfortunately, overall progress towards both of these objectives has been slow. In response, a group of leading European nongovernmental organizations (NGOs) working in the field of sexual and reproductive health and rights (SRHR) has joined forces under the banner of Countdown 2015 Europe, to ensure that universal access to reproductive health becomes a reality in developing countries.

Countdown 2015 Europe has a special focus on reproductive health supplies (RHS). Clearly, reproductive health services cannot meet people’s needs if contraceptive supplies are not available and affordable. This may seem obvious, but in many countries people are receiving contraceptive advice yet cannot access the contraceptive supplies they need to protect their health. The partners of Countdown 2015 Europe aim to increase support from European donors for RHS in developing countries, and to improve European coordination and coherence to narrow the gaps between the needs, demand and availability of RHS. This is an essential step toward achieving the MDGs.

2. Research: State main question/hypothesis

The main question addressed in this research is: How much funding are European donors providing for reproductive health and RHS more specifically? What are the baseline funding levels, and what progress is being made in increasing the level of funding and donor transparency and accountability with regard to budgets and expenditure for RHS?

3. Methodology

The Countdown 2015 Europe reports (2008 and 2009) analyze data from the EU institutions and 15 European national governments (see above list with countries where Countdown 2015 Europe partners are based) related to funding for sexual and reproductive health and rights (SRHR), and for reproductive health supplies (RHS) specifically, in order to monitor progress in increasing the level of funding and donor transparency and accountability with regard to RHS funding. The report creates a baseline for monitoring progress in increasing the level of funding and donor transparency and accountability with regard to RHS funding.

4. Data

Data were collected by the Countdown 2015 Europe partners through desk research of the most recent official financial report from their governments as well as face to face contact with government officials.

5. Findings & 6. Research: State knowledge contribution
The reports give an overview of donor spending on RH and RHS and identify champions on the subject. However, finding show that it is extremely difficult to identify funding support specifically for RHS, because funding streams in these countries and organizations are complex, highly varied and often confusing. None of the countries or organizations have a budget line devoted specifically to RHS, and each has different budget lines which could potentially cover SRHR and/or RHS (e.g. budget lines such as ‘health’ and ‘HIV/AIDS’). A lack of transparency on how the money is spent makes it very difficult to identify RHS funding.

Hence, Countdown 2015 Europe partners urge European donors to be more transparent and publish what they fund, so that monitoring of RHS funding can lead to aid better spent. The recent trends in the new aid architecture of European donors opting for increased general and sector budget support and funding for health systems strengthening add to the complexity in tracking funds for RHS. Also, funding to global health initiatives (like targeted financing to the GFATM; new financing mechanisms like UNITAID; and coordination mechanisms like the IHP+) make it very difficult for European advocates to ask for specific funding figures on RH and RHS.

In a response to the above challenges in a European context, Countdown 2015 Europe has carried out additional desk research on the Role of RH and RHS in Strengthening Health Systems.

By combining the above findings on tracking funding for RH and RHS as well as the role of RH and RHS in strengthening health systems, Countdown 2015 Europe partners have come up with advocacy messages for European donors adjusted to the current policy trends and climate. It shows the importance and challenges of how costing numbers can be used for advocacy in a specific European context.

G05: 4
Euromapping – how the costings are used for advocacy!
Karen Hoehn1, Neil Datta2
1German Foundation for World Population (DSW), Belgium; 2European Parliamentary Forum on Population and Development (EPF); sdennis@popact.org

1. Background/Significance
Many developing countries experience low contraceptive prevalence rates and worldwide some 204 million women have an unmet need for family planning services. Annually an estimated 536,000 women die in childbirth worldwide, of which some 66,500 are the result of unsafe abortions. Some 100 million young people are among the 340 million new cases of sexually transmitted infections each year.

In 2007, universal access to reproductive health services was integrated as a target of the Millennium Development Goals. At the International Conference on Population and Development (ICPD) funds to reach this goal were estimated at US$18.5 billion in 2005, US$20.5 billion in 2010, and US$21.7 billion in 2015.

In 2009, governments, parliaments and civil society will take stock of achievements regarding the ICPD Programme of Action. Today, it is clear that funding levels pledged 15 years ago, have not been achieved. Despite significant private contributions, most funding for health initiatives around the world still comes from governmental donors, predominately through Official Development Assistance (ODA). Thus, monitoring the level and composition of ODA is a means of verifying whether governments are living up to their political and policy commitments.

2. Main Question and Interventions
The goal of Euromapping is to research, analyse, consolidate and present comparative information about European ODA and SRH commitments, funds flow and qualitative considerations that will help advocates and policymakers increase resources for global SRH and improve harmonisation SRH donor policies. Euromapping has been and still is the only instrument that combines data from multiple sources such as the European Commission, the Organisation for Economic Cooperation and Development (OECD) and UNFPA/NIDI to produce analysis specifically calibrated to meet the needs of SRHR advocates and decision-makers.

Euromapping creates peer pressure among European NGOs, decision makers, ODA officials and the media to increase funding for global sexual and reproductive health and rights (SRHR) and development cooperation.

Euromapping is a comprehensive study analysing EU development aid for population assistance. It “names and shames” good and bad performers, and includes specific recommendations to improve reproductive health and reduce poverty.

3. Methodology, Data and findings
Euromapping 2009 has a total duration of 12 months and the main activities take place in Belgium (EU-level), France, Germany, Hungary, Italy, Latvia, the Netherlands, Romania and the United Kingdom. The project follows the principle of subsidiarity: What can be implemented effectively at the national level is handled nationally. Hence, DSW provided sub-grants to selected NGOs in order to implement the dissemination and advocacy activities at national level in France, Hungary, Italy, Latvia, the Netherlands, Romania and UK. Activities at Brussels-level are implemented by DSW EU Liaison Office hand in hand with EPF and activities in Germany are implemented by DSW headquarters. This method has been chosen, in order to ensure maximum efficacy, efficiency and success. Euromapping findings are best conveyed to the general public by national NGOs. These NGOs also have better entries to parliamentarians and ODA officials. Nonetheless, activities are steered from Brussels level, which is Europe’s nerve centre.

Our methodology has the concept of peer pressure at its core: It is a phenomenon encouraging a person to change its attitude and behavior to conform to a peer group’s standards. In development cooperation, the EC increasingly has the role of such a peer group: The European Consensus on Development is its common standard and at the European Development Days the governments compete with their activities. Our project makes use of this, by creating pressure among the target groups. This raises awareness among the population and creates public pressure on decision makers to improve their performance.

The data used in the research includes: (1) Review of: NIDI data, European bilateral ODA reports, OECD data, EU annual development cooperation data, EU developing country strategy papers approved in 2007 and payments to UNFPA, UNAIDS, IPPF, the Global Fund for AIDS, TB and Malaria. (2) a survey of large European-based humanitarian relief and development NGOs with known SRH and HIV/AIDS activities. (3) A compilation of case studies on the use of budget support in relation to SRHR (Sub-Saharan experiences). (3) Monitoring and follow-up the development aid effectiveness in light with the Accra Forum to be held in 2008. (4) Analysing this information relative to funding targets and other criteria and compare it to policies and trends of individual European donor countries.

6. Knowledge contribution and lessons learned
On the occasion of ICPD at 15, Euromapping 2009 differs significantly from previous versions and its scope and scale is expanded considerably. In September, DSW and EPF will jointly release the Euromapping 2009 Pocketguide, featuring:

• General ODA trends
• Health spending
Men’s Reaction to wife’s covert use of contraceptives: Implication for Family Planning Practices in Southwest Nigeria

Peter Olasupo Ogunjuyigbe 1, Gbolahan Oni 2, Sunday Adedini 3

1Obafemi Awolowo University, Ile-Ife, Nigeria; 2Johns Hopkins Bloomberg School of Public Health, Maryland, USA; pogunjuyigbe@yahoo.com

1. Background

Studies have shown that in many developing countries, significant proportion of women use contraceptive without the knowledge of their husbands. The fear of their husbands is a factor identified in the literature as militating against the acceptance and use of contraception. In sub-Saharan Africa and in the more patriarchal societies like Nigeria, decisions related to sexual and reproductive health are made by men, whereas sexual and reproductive health in its broader sense should be the concern of both husband and wife. Subsequently, many women are afraid to raise the issue of contraception for fear that their partners might respond violently.

In some cultures within the sub-Saharan African countries, men actually oppose their wife’s adoption of contraceptives. Men’s opposition to contraception is hinged on some reasons one of which is that it encourages irresponsible sexual behaviours. Some recent studies also show that some men still hold the idea that, women are morally weak and unable to control their appetite and implicitly her body and sexuality. There is the belief that “no matter who and how a woman is, her intellect is very small” and as such, her use of family planning should be subjected to the husband’s control. Also, the perception of women as their husband’s property and of childbearing as their primary role in society is another crucial reason.

All the aforementioned factors constitute impediment to the acceptance and use of contraception by women even when they do not want to have more children. Consequently, in Nigeria and some other countries where contraceptive prevalence rate is low, some women often use contraceptives without the knowledge of their husbands or with their husband ignorance of specific methods, often referred to as covert use of contraceptive.

2. Hypothesis/Intervention

In spite of all these realizations, there is a paucity of demographic data on the reactions and attitude of men to their wife’s covert use of contraceptive and the implication this may have for family planning practices in Nigeria.

3. Methodology

The data used in this study were derived from a study carried out between May and July 2004 in two local government areas Osun State, Nigeria. The state has 30 Local Government Areas with a total population of 2,158,143 (1,043,126 males and 1,115,017 females) and 485,637 households in 1991 (FGN, 2008). Within the state, Ife South (rural) and Ilesa West (urban) Local Government Areas were randomly selected for the study. Two communities, Ifetedo in Ife South and Ilesa in Ilesa west local government areas, were selected. The primary respondents are 400 married men aged 15-64 years old, while their wives constitute the secondary respondents.

4. Data

Both quantitative and qualitative methods were used to elicit information from the respondents. For the study to be truly representative of the community, Ilesa being an urban centre, was divided into four zones to reflect the residential patterns. Selection of respondents in the rural area was based on a simple random sampling; however, the selection was made in such a way that all the different parts of the rural location were represented. At the end of the survey 369 men and 382 women were successfully interviewed. In each community, four male and four female groups in age groups 15-24 years, 25-39 years, 40-59 years and 60 years and above were constituted and were involved in the focus group discussion. Data from the questionnaire were coded and then entered into the computer using Microsoft EXCEL software; SPSS software was however used for subsequent analyses.

5. Findings

The study showed that gender role ideologies still place men in a dominant position in household decision-making, which includes decisions on contraceptive use. Both men and women in the study area agreed with the statements that men should decide when to take firm decision on family planning (42.6 percent) as well as on problem associated with unwanted pregnancy (57.3 percent). The majority (80.1 percent) of both men and women involved in the study favoured the use of contraceptives by women only when it is approved by their husbands. About 36 percent of the women gave an indication that their spouses would not stop them from using family planning methods; while only 14 percent of the women claimed to have used methods without their husband’s knowledge. On men’s reaction to women’s covert use of contraceptive, about 42 percent of the men said ‘they would be annoyed’ and would sanction their wife or that the woman would bear alone any risk associated with such use; a quarter of the men gave an indication that they would be embarrassed.

6. Knowledge contribution

Because of the socio-economic and political dominance of men in the household, the findings in this study signify serious challenges to the implementation of the various efforts of family planning programmes.

P3: 2

Good practice in creating access to FP service for the rural youth: A case study on Dhalotake Egl Youth SRH Clinic

Feyera Assefa Abdissa

German Foundation for World Population (DSW) Ethiopia, Ethiopia; feyera.assefa@ethionet.et

Background:

In order to address adolescent sexual and reproductive health problems, different strategies have been developed and implemented in Ethiopia. DSW/Ethiopia, as one of the main actors, has developed youth to youth model to enable adolescent and young people tackle their own problems in a comprehensive way. The approach is designed in such a way that youth are organized into clubs and associations to provide ASRH information through peer approach and ASRH services.
through referral linkage with the nearby health facilities. The situation is different in rural areas where there is shortage or lack of health facilities. Besides, the youth prefer to get the service in youth friendly set up and approach because of fear of stigma emanated from societal attitude towards young people’s sexuality. Hence many young people are exposed to problems like unwanted pregnancy, sexually transmitted infections including HIV/AIDS and other SRH problems. In order to see the service utilization of young people by age, marital status and method preference, four year service statistics of Dhalotake Egi youth SRH clinic were analyzed. It was also intended to see, in a rural context, the importance of integrating youth friendly clinic to youth associations and how much it contributed to protect couples from unintended pregnancy.

Methods
In order to grasp contraceptive use of adolescent young people over an extended period of time, service utilization statistics for four consecutive years (2005-2008) from Dhalotake Egi youth friendly SRH clinic were analyzed using statistical tools such as frequency tables, percentage distribution and mode and media. The data were collected from the daily registration books were disaggregated by age groups, FP methods and marital status.

Results
Over 49,830 family planning commodities have been distributed to rural married and unmarried youth through the clinic. These include depo provera, pills and condoms. As a result, unintended pregnancy among unmarried and married youth were prevented. The service contributed about 1225.06 couple’s year of protection (CYP). More than 90% of adolescents and young people 15-25 years used condoms and only about 2% used pills. On the other hand, about 84% of adolescent and young people 25-35 years used condoms and about 12 % and 4 % used pills and depo provera respectively. This shows that there is a preference for condoms among young people. The increase in the percentage of pills users depicts the method preference of married youth , while the increased preference for Depo provera indicates the need for long term FP methods.

Conclusions
The club/association based youth friendly clinic approach improved access to family planning service for married and unmarried youth, particularly in rural areas. However, a need assessment need to be conducted to identify and integrate long term and permanent FP methods.

P3.3
Male Issues in Cases of Unwanted Pregnancy and Abortion Resolution in Southwest Nigeria
Peter Olaojupogunjuigbe, Ambrose Akinlo, Ayotunde Titilayo, Akanni Akinyemi
Obafemi Awolowo University, Ile-Ife, Nigeria, Nigeria; pogunjuigbe@yahoo.com

1. Background
Unsafe abortion has been a great threat to safe-motherhood and has contributed in no small magnitude to maternal mortality and morbidity globally. Approximately 70,000 women die annually as a result of complications arising from unsafe abortion. Unfortunately, most of these events happen in developing countries.

Performing an abortion is a criminal offence under Nigerian law, unless the pregnancy threatens the woman’s life. Consequently, the practice of abortion is shrouded in secrecy because of its illegality and due to religious and social norms opposition. In spite of its illegality, available statistics still indicate that abortion is a leading cause of maternal mortality in Nigeria accounting for about 50 percent of maternal deaths. Abortion has also been implicated as a cause of secondary infertility, ectopic pregnancy, mid-trimester abortions, and preterm labour in Nigerian women.

Also, in Nigeria, contraceptive knowledge is low and access to family planning services is poor. The 2003 National Demographic and Health Survey results indicate that while 13 percent of currently married women are using a method of family planning, only 8 percent are using a modern method. Consequently, cases of unplanned pregnancies, especially among young unmarried women are increasingly common. Ironically, cases of unwanted pregnancies and abortions are not peculiar to young unmarried adolescents alone, many of the married women also engage in illegal and clandestine abortions for diverse reasons. Evidence from Demographic and Health Survey (DHS) revealed that many women who want to avoid pregnancy are not using contraceptives because their husbands object to it.

The 1994 International Conference on Population Development (ICPD), held in Cairo, Egypt emphasized men’s shared responsibility in sexual and reproductive health as well as the benefit of men’s active involvement in responsible parenthood and reproductive health.

2. Hypothesis or Intervention
The role of men either covertly or overtly, directly or indirectly is of significant determinant in cases of reproductive decision-making. In spite of the low prevalence of contraceptive, high rate of unwanted pregnancy and the danger of and threats of induced abortion on the reproductive health and lives of women, little effort has been made on the documentation and studies of the male partners’ involvement in decision making process among Nigerian couples. Also, the attitude and characteristics of men in influencing contraceptive and abortion decisions in various ways has not been adequately researched and documented.

3. Methodology
The data for the study were obtained from a survey which took place in Osun state between April and June, 2001. Abortion is a leading cause of death especially among youth and adolescents in the state. Within the state, Ilesa town, broken down into Ilesa East and Ilesa West Local government areas (LGAs) was purposely selected. The town was divided into four strata based on the housing structure and pattern, economic, educational and social consideration.

4. Data
Simple random sampling procedure was then used to select a street from a list of streets in each selected settlement. From each of the selected streets, systematic random sampling method was used to select the housing units from which the respondents were interviewed. Only one eligible male respondent aged 18 years and above (married or not married) was interviewed in a selected household. On the whole 297 respondents made up of 166 married males and 131 unmarried were successfully interviewed. However, the unmarried men may likely include those men who were once married but are now divorced, separated or lost their wives to mortality. Data from the questionnaire were coded and then entered into the computer using Microsoft EXCEL software; SPSS software was however used for subsequent analyses.

In the analysis, marital status was controlled for responses of the selected variables. Respondents’ marital status is considered a very important variable in the study of gender activities and roles in unwanted pregnancy and abortion decision. It is generally believed that reproductive health and fertility decisions and attitudes differ according to marital status of the individual concerned.

5. Findings
The study confirmed the prevalence of unwanted pregnancy and abortion in the area with 45.6 percent of the respondents reporting to have been involved in cases of unwanted pregnancy at least once. About 69 percent of the men knew of early pregnancy signs; however, majority of these men are married. The study shows that more of the single men have had a female partner with cases of unwanted pregnancy (46.8 percent as against 43.8 percent among unmarried men). The study indicates that though male partner is responsible for all the expenses incurred on abortion process, however, female contribution towards abortion process is also significant (p<.01).
6. Knowledge contribution or lesson learned
It is evident from the study that the perceived role of men in reducing the prevalent high risk of unsafe abortion need to be properly researched and that intervention programmes in preventing unwanted pregnancies directed towards male partners have to be fully implemented.

P3: 4
Adolescent Reproductive Health Policy Implementation in Ghana: A Review of the Service Provision Component in the Accra Metropolis

Fred Gbagbo
Marie Stopes International Ghana, Ghana; gbagbofredyao2002@yahoo.co.uk

1. Background to the study
In Ghana, adolescents (10 – 19 years) constitute 22% of the total population. Although Ghana developed very comprehensive Population and Reproductive Health Policies as far back as 1969 and 1996 respectively, there seem to be very little provision made for the reproductive health needs of adolescents. Recognizing the gap, the National Population Council (NPC) together with her partners in 1996 produced an ARH Policy to complement the Revised Population Policy 1994 and the RH Policy 1996. The ARH Policy was to provide broad guidelines for all stakeholders in ARH to ensure comprehensive, efficient and effective ARH that will avert the wasting of lives of adolescents. Despite this policy, there were still reproductive health problems confronting adolescents in the country. It was in relation to this observation that the study reviewed the service provision component of the ARH Policy implementation to document and disseminates the key findings among all stakeholders for action.

2. Main research question.
Within five years of the development of the ARH Policy document in Ghana (2000-2005), the Ghanaian Media increasingly published public concerns about the sexual and reproductive ill health of adolescents. These public concerns and observations directly or indirectly question the adequacy, effectiveness, efficiency, responsiveness and the relevance of the ARH Policy and its implementation in the country.

3. Methodology
Study location, setting and periods
The Accra metropolis was the study location in 2005. Accra is most densely populated urban metropolis of Ghana, with a total population then of 1,658,937. The Metropolis is divided into six (6) sub-metros namely, Ablekuma, Ashiedu-Keteke, Ayawaso, Kpesie, Okaikoi and Osu-Klottey. Each of these sub-metros is treated as an administrative district because of the size of their population and the complexity of the sub-metro health system. Administratively, the Metropolis is governed by the Accra Metropolitan Assembly and headed by a Metropolitan Chief Executive. There are many ethnic groups that speak approximately 44 languages. Trading is the main economic activities of the populace. The health of the people in the Metropolis in general was then improving partly due to the availability of several health facilities.

4.0 Data collection and Analysis
Due to the study methodology, primary data from the field and desk review of secondary data from reports were collected. This lead to the use of both qualitative and quantitative data. In harmony with the study objectives, two methods were employed for the data analysis. In the case of the quantitative data, responses were summarized, tabulated and interpreted in the form of frequency tables and graphs using Microsoft Excel and Epi info statistical packages.
Qualitative data were analyzed in prose (narrative).

5.0 RESULTS AND FINDINGS
Key findings from the study indicate that, the National Population Council (NPC) after developing the ARH policy in October 2000 was not able to either launch or disseminate the policy at the national, regional or zonal levels due to resource constraints. Awareness and use of the ARH policy was also woefully inadequate and the implementation of the service component of the ARH policy in the Accra metropolis has never had adequate support needed from the government. High adolescent numbers in the metropolis coupled with inadequate financial commitment from the government as well as inhuman attitudes towards ARH were among the major challenges hindering the policy implementation in the Accra metropolis.

6.0 Knowledge contribution
The findings of this study have given some insight into how the Adolescent Reproductive Health Policy is being implemented in the Accra Metropolis of Ghana. It has underscored the various issues related to the policy implementation with respect to ARH care service provision and the need to address some identified problems in a holistic manner so as to achieve the policy goals and objectives. The fact that the existence of the ARH policy is not too well known among ARH care service providers and recipients calls for the launching of the policy as well as its widely dissemination within the metropolis to increase awareness and usage by all stake holders. Most importantly, the government needs to allocate adequate resources towards the provision of ARH care services in the Accra Metropolis. This also calls for a well coordinated and harmonized ARH care service provision in order to ensure a uniform service provision to adolescent in both private and public health facilities within the Accra metropolis.

P3: 5
Utilization of Family Planning Services by Adolescents: A Katuba Experience.

Victor Silumbwe, Kalenga Lesa
Katuba Community Association, Zambia; vslumbwe@yahoo.com

Background
Katuba Community Association is currently implementing The Adolescent sexual and Reproductive project. The project was designed through a community needs assessment which employed participatory rural appraisal(PRA) and participatory learning and action (PLA) tools in 2007 in katuba catchment area. The findings of these studies found that there was low access and utilization of family planning services by adolescents and young people. This was evident by the
increased number of teenage pregnancies and early unplanned teen marriages caused by early pre-marital sexual practices compounded with lack of adequate and accurate information on Family Planning.

The Adolescent sexual and Reproductive Health Project is a 3 year project being funded by Chibombo Child development Agency and Christian Childrens Fund. The project uses the concept of the peer education approach to its programming. It targets adolescents and young people between the ages of 14 - 24 years and hopes to reach 1600 adolescents and young people.

The project is being implemented in partnership with the local health centre, schools and other community based organisations.

Program Objective
To increase access and utilization of family planning services by 50% among adolescents and young people by 2010 in Katuba Catchment Area.

Program Intervention
1. Creating awareness on the importance and benefits of family planning through community based participatory approaches (mass media) in villages within katuba catchment area.
2. Conducting technical capacity building trainings on current trends on family planning to adolescents and young people as key partners in the project, heath workers, teachers, village headmen, church leaders and community leaders in katuba catchment area.
3. Monitoring the number of adolescents accessing family planning services within katuba catchment area

Program data
Currently, data from the monitoring tools indicate that there is a gigantic increase in the number of adolescents and young people accessing family planning services in katuba catchment area. Apparently, there are 789 adolescents and young people who are accessing the services.

Lessons Learnt
1. Condoms and oral contraceptives are the family planning services widely used by adolescents and young people.
2. In the initial stages adolescents and young people feel uncomfortable using condoms but with time and consistent use they eventually get used to it.
3. Traditional misconceptions that family planning methods are for the elders are slowly being broken.
4. Adolescents and young people are appreciating the information they are getting on family planning.
5. Adolescents and young people involvement and participation in the program has been critical and a core business of the organization
6. Community partnership and support has enhanced community ownership of the program
7. Youth - adult partnership has greatly helped developing adolescents and young peoples dynamics.

P3: 6

Factors Affecting Contraceptive Use and Method Choice Among Young Married Women in Bangladesh

S. M. Mostafa Kamal
Islamic University, Kushtia-7003, Bangladesh; kamaliubd@yahoo.com

1. Background/Significance
Young women are particularly vulnerable to higher risks of unwanted pregnancy, abortion and Sexually Transmitted Diseases (STDs) including HIV. These vulnerabilities are important public health, social and demographic concern. As a result, contraceptive use and method choice among young women have recently captured a lot of research interests. Enabling contraception use is vital for meeting the goals of prevention of unwanted pregnancy, STDs and HIV.

2. Hypothesis or intervention/Activity tested
Bangladesh has long tradition of early marriage and early childbearing. More than half of the total fertility rate (TFR) is attributed to the young women aged 15-24. Three out of four women experience motherhood before age 25. Unwanted pregnancy and abortion are also common. Although the contraceptive prevalence rate (CPR) is relatively high in Bangladesh, little is known about contraceptive use of the young women. Higher incidents of pregnancy, increased risk of STDs and vulnerability to HIV suggest the need to understand the factors affecting contraceptive use and method choice among the young women.

3. Methodology
The study dealt with nationally representative weighted sample of 3471 currently married women aged 15-24 extracting data from 2007 Bangladesh Demographic and Health Survey (BDHS). The data collection took place over five months from March to August 2007. Both quantitative and qualitative statistics have been used to examine the association and effects of various socioeconomic, demographic and programmatic factors on contraceptive use and method choice. To investigate the factors affecting contraceptive use of the young women we applied binary logistic regression analysis. Besides, we performed multivariate multinomial logistic regression analysis to estimate the risk of traditional and modern method preferences for selected variables. The results of regression analyses have been presented by odds ratio (OR) with 95% Confidence Interval (CI). All of the statistical analyses have been performed by SPSS 11.5 software.

4. Data (if relevant)
The 2007 BDHS is the latest nationally representative survey of 10996 ever married women of reproductive age and 3771 men of age 15-54. The survey obtained detailed information on fertility, marriage, awareness and use of family planning methods, nutritional status of women and children, knowledge and attitude regarding HIV/AIDS etc. Such a large data set provided a unique opportunity to study the contraceptive use and method choice among young married women of Bangladesh.

5. Findings
Knowledge of at least one modern contraceptive method is universal in Bangladesh. Overall, the CPR among young married women was found to be 47.2%; included modern method 42.5% and traditional method 4.5%. The most preferred modern methods were pill (31.9%), injections (5.5%) and condom (4.5%), while withdrawal (2.4%) was the most used traditional method. The highest variation of contraceptive use rate was observed in the administrative regions, ranges from 21.6% to 56.6%. The both bivariate and multivariate analyses identified several variables as important determinants of contraceptive use such as region, women’s education, women’s work status, wealth index, mass media exposure, Family Planning Workers’ (FPW) visitations, NGO membership, number of living children and child mortality. The multivariate multinomial logistic regression analysis yielded significantly (p<0.001) increased risk of modern method
Unmet Needs for Contraceptives for Young Undergraduates in Selected Tertiary Institutions in Southwestern Nigeria.

Ibitayo Abiola Odu, Lanre Olusegun Ikoteyijo
Obafemi Awolowo University, Ile–Ife, Nigeria; t_odu@hotmail.com

Unmet Needs for Contraceptives for Young Undergraduates in Selected Tertiary Institutions in Southwestern Nigeria.

Background/Significance
Young people in Nigerian tertiary institutions belong to the sexually active age, and studies have shown low contraceptive use among them despite high level of sexual activities. University health centers provide primary care services to students and represent a key factor in respect of access to contraceptive services and information. The degree to which these facilities appropriately respond to the reproductive health needs of unmarried undergraduates is, however, unknown. This study therefore attempts to examine the quality of reproductive health delivery which includes contraceptive access and policies guiding the delivery of these services to young undergraduates in some universities in southwestern Nigeria.

Main Question/hypothesis
The broad objective of the study was to assess the unmet needs for contraceptives for young university students using the policies of university based health institutions as well as the attitude and perceptions of workers in these institutions as critical variables. The study specifically aimed at comparing the extent of youth friendliness of selected universities in southwestern Nigeria and to examine factors associated with attitudes of staff of university based clinics to reproductive health services provision to the youths.

Methodology
The study was conducted between November and December 2008 in six universities located in the southwestern part of Nigeria – two of which are federal government owned, two are state government owned and the other two privately owned. The study involved mainly staff of the health facilities located in these schools. The methods used for data collection were focus group discussions for sundry health workers which included doctors, pharmacists, laboratory technologists, nurses and others, while in depth interviews were conducted with medical directors of the institutions. The FGDs comprised of both male and female medical staff; seven medical doctors, four pharmacists, nine nurses, two medical laboratory scientists and three other health care providers which included a social worker. Permission to carry out the study was obtained through the medical directors of each institution and the staff were informed about the objectives of the study, while they all gave their consent.

Findings
Among the major findings of the study was that all facilities investigated reported high unmet needs for contraceptives for young undergraduates. None of the health facilities had separate clinic days for consultation for undergraduates, while four of the six schools did not have any policy guideline for provision of reproductive health to undergraduates. Also only two of the six selected schools had youth friendly centers where students could access information on reproductive health services, even these centers were underutilized by the young undergraduates. Finally, most of the respondents agreed that their personal values would affect their decision to give reproductive health services (particularly contraceptives) to unmarried undergraduate students and there was a consensus of opinions among respondents that the provision of contraceptives to unmarried undergraduate students would make them to be promiscuous. Denial or lack of full range reproductive health services to youths in university based health institutions has potential to lead to situations of unmet RH needs of the students thereby leading to patronage of unsafe sources.

Knowledge Contribution
The findings from this study showed that there were no specific policies in some of the schools, except for the federal universities such that reflect a pro-youth friendly provision of reproductive health services. Instead, personal values provided a general framework for some of the services either covertly or overtly in many of the institutions. The major contribution of this work is that it presented the unmet needs for contraceptives for youths from an institutional-based perspective, particularly the main institutions saddled with the responsibility of providing primary care services to students. The study exposed the need to involve the services social workers in reproductive health matters especially as it concerns young people.

The impact of voluntary activities of medical students in promotion of Family Planning.

Egide Abahuje
Family Planning Education Project, Rwanda; abegid1@gmail.com

1. Background/Significance
Rwanda, like other developing countries are struggling to get developed through different efficient ways, but still demographic problems is still a great challenge that those countries face. The population is increasing highly; to prove this, according to the USAID country health statistical report of November 2008, the Rwandan population was 6,981,760 in 1990, in 2000 it was 8,278,209, in 2008 it was 9300000 and if nothing done, this number will double in 2030.
To limit this high population growth rate, the ministry of health in Rwanda has made family planning a priority. In addition to this some Non Government Organizations have contributed to this government policy. It is in this perspective that Family Planning Education Project has been created in 2004 under the
cooperation between two medical students’ organizations; MEDSAR (Medical Students’ association of Rwanda) and IMCC (International Medical Cooperation Committee) from Denmark. The objective of the project is to increase the number of people who use contraceptive methods, to promote birth spacing and to reduce the incidence of HIV/AIDS and sexually transmitted infections.

2. Intervention

Family Planning Education Project is made of 40 medical students who work at a volunteer basis and make teaching sessions where they teach the rural community the role of family planning to the community, contraceptive methods, HIV/AIDS and STIs prevention and gender issues related to family planning.

3. Methodology

To achieve our goal, we firstly make teaching sessions on ten health centers of HUYE District in the southern province where we meet women who seek for services like prenatal consultation, nutritional aid, vaccination,... During our teaching sessions we explain to participants the importance of family planning to women, to children, to their husbands and to the whole country, and thereafter tell them different contraceptive methods available in Rwanda and ask them to start using contraceptive methods especially the long acting ones. We also encourage them to use condom as it offers a dual protection; in prevention of unwanted pregnancies and HIV/AIDS and STIs.

Secondarily, after realizing that men can play an important role in family planning as they are the ones who take the last decision in Rwandan families, we launched another frame and strategy through which we included men in our target group and we allow men and women to discuss about reproductive health and contraceptive methods.

Finally we thought that contraceptive methods are not only reserved for couples but also for single; especially adolescents, we thereby included youth; the one who did not get the opportunity of studying secondary school.

4. Data

To evaluate the impact of our activities, we use always count the number of participants who attend each session. We, also after each session, ask some questions to participants, and thereby assess what they gained from our teaching. During the annual evaluation, we collect data from health centers with which we work and assess the number of new cases who ask for contraceptive methods and the most used method.

5. Findings

As results of our activities, since 2006,

32562 women have been taught on family planning.

2538 men have been taught on family planning.

32567 adolescents have been trained on reproductive health and contraceptive methods.

We have found that the number of women using contraceptive methods in ten health centers we work with has shifted from 2779 in 2006 to 6890 in 2009.

We have found that the number of new women asking for contraceptive methods in ten health centers have increased from 234 in 2005 to 784 in 2009.

We have found that 58% of women using contraceptive methods use depo provera.

6. Lessons learned

After three years of volunteering in Family Planning Education Project, we realized that inclusion of men in family planning is a paramount especially in developing countries where gender balance is still in progress. We also realized that integration of family planning and HIV/AIDS prevention is efficient as there are some methods that offer a dual protection. In addition to this, we realized that while teaching contraceptive methods we should focus on long acting methods as they require less attention and follow up of the user. We finally learnt that partnerships of youth from developing countries and those from developed countries are most important as they offer firstly both youth to learn from community based activities and secondarily the community benefit from youth activities.

P3: 9

SRH needs and service utilization of young students of Addis Ababa University

Yordanos Belayneh Molla

IC: Health Sector Development Prgram (HSDP), Ethiopia; jordi_belayneh@yahoo.com

1. Background - This study examines sexual and reproductive health (SRH) service utilization among students of Addis Ababa University (AAU) through the theoretical lens of the Health Belief Model. The university has been hosting students coming from all parts of the country usually away from their family. To this effect students are exposed to new environment, substance abuse, and many risky sexual behaviors ranging from unprotected sex with fellow students to practicing commercial sex work in town.

2. Hypothesis- This study aimed to assess the SRH needs and service utilization of young students of AAU.

3. Methods- The study was conducted between September 2007 and July 2008 in five campuses of AAU. The study employed a cross-sectional study design involving quantitative and qualitative methods, review of records and observation of university clinics with checklist. The qualitative study was conducted among a purposively selected sample of 15-29 years old day time students and among university health service providers. Ten In-depth Interviews and 11 Focus Group Discussions were conducted. Five departments were randomly drawn from five randomly selected campuses of AAU. A total of 633 students were chosen randomly to fill a pre-tested self-administered questionnaire. The quantitative data were processed using the SPSS statistical software. Taped qualitative data were transcribed, translated into English, and analyzed by grouping into similar thematic areas.

4. Findings:

Greater utilization of SRH services was reported by students attending in two campuses with information and education programs by external NGOs (p<0.001; CI: 2.48, 20.25 and p<0.001; CI: 3.08, 20.99). And key driver of low utilization of SRH services on campus was dissatisfaction with the quality of service. The barriers to service utilization include the lack of preferred services, inconvenient clinic location and working hours, the high cost of services, and bureaucratic referral systems. Further, a large number of students (69.3%) were unaware that SRH services were provided at university clinics and students especially first years, female students and those coming from the rural areas face problems due to lack of awareness. Indeed the lesser proportion of students that are using any form of contraceptive (29% of the sexually active students) despite the presence of unwanted pregnancies; and the lesser proportion of female students that are using condom consistently (11% of the consistent condom user) are indicative of the gap in addressing SRH need of students. Record review in one NGO clinic also confirmed the situations as there were 80 students that underwent pregnancy test and 78 students that took emergency contraceptives in one
Contraception Among Out of School Females

Kofoworola Abimbola Odeyemi1, AT Onajole1, BE Ogunowo1, B Segun2

1University of Lagos, Nigeria; 2Federal Ministry of Health, Abuja. Nigeria; kfoodeyemi@yahoo.com

BACKGROUND/SIGNIFICANCE

Unprotected sex puts young people at risk of unwanted pregnancy which may contribute to their dropping out of school, marrying early, abandoned babies, obtaining unsafe abortions, contracting HIV and other STIs. Contraception is the first line of defense against unwanted pregnancy. This implies that unwanted pregnancy and its complications are avoidable if contraceptive methods are offered in an acceptable manner to every community. Understanding the extent to which young people know and use contraceptives is therefore a significant issue for research and policy.

A large proportion of adolescents in Nigeria are engaging in premarital sexual activity. However, the contraceptive prevalence rate among them is low. Since induced abortion is illegal in Nigeria, many adolescents who experience an unplanned pregnancy resort to abortion often under unsafe conditions with negative consequences. The alternative ought to be a reasonable and responsible adoption of modern contraceptive methods. Adolescents are usually not targeted for family planning programmes in Nigeria. More research is needed to deepen our understanding of the factors that influence contraceptive use among adolescents and to provide information which is needed to justify and guide the design of effective programmes to meet their needs.

Young people are now less sheltered from the realities of the adult world. This is particularly true for those who leave school early leaving behind the relative shelter of the school community. This study was conducted among out of school female adolescents working in markets in Lagos, Nigeria. The objective of the study was to assess their knowledge, attitude and use of contraceptives and to identify the factors that influence contraceptive use amongst them.

METHODOLOGY

This study was conducted in 2 major markets in Lagos, Nigeria; Sandgrouse and Mushin markets. Female adolescents work in both markets as maids, apprentices, shop assistants and petty traders. The study population was the single females between the ages of 10 and 19 years who had never been to school or who had stopped schooling. Using cluster sampling technique, a representative sample of 682 adolescents was recruited within the markets to participate in the study. Data was collected by using interviewer administered questionnaires. The Epi Info statistical software was used for data entry and analysis. The association between selected variables was examined using chi – square and Fishers test. Possible interactions between variables were examined by performing multivariate analysis. Differences and associations yielding p values of 0.05 or less were considered statistically significant.

DATA/FINDINGS

Majority (81.4%) of the respondents had heard of contraception. However their awareness of contraceptive methods was poor: Only 35.2% were aware of oral contraceptive pills and 42.4% were aware of male condoms. Very few (1.76%) had heard of emergency contraceptives. Their main sources of information were their friends (51.85%), radio/television (26.6%) and sexual partners (23.1%). Majority of respondents (70.3%) felt that sexually active adolescents should use contraceptives. However, half of them (50.6%) believed that contraceptives are harmful.

Over half (52.9%) of the sexually experienced adolescents had never used contraceptives, yet almost all (95.8%) stated that they did not want to get pregnant. Fear of side effects, partner’s refusal, the belief that they will not get pregnant and “not thinking of using them” were the main reasons given by the sexually experienced respondents for not using contraceptive methods. Among those who were currently using contraceptives, the main methods being used were: male condoms, oral contraceptive pills and traditional methods.

The respondents age (OR = 0.96, p<0.05) and religion (OR 0.84, p <0.05) did not influence contraceptive use. Respondents’ knowledge and beliefs about contraception influenced their contraceptive use. (p<0.05). Current use of contraceptives was influenced by number of respondents sexual partners (p<0.05).

The findings show that there is an unmet contraceptive need among out of school female adolescents.

KNOWLEDGE CONTRIBUTION

Pregnancy prevention is a major concern among sexually active young people. This study provides information on contraception among a vulnerable group.

The results highlight the need for adolescent focused family planning programmes and services and identify knowledge gaps and misconceptions to guide the content for health education interventions.

The findings provide data for advocacy to raise awareness on sexual health problems of adolescents and for policy makers to make evidence based decisions in the development of programmes for out of school adolescents to raise contraceptive awareness and use.

Promoting Gender Equity as a Strategy to Change Contraceptive-Related Attitudes and Behavior among Young Men in Rural India

Ravi K. Verma1, Ajay K. Singh1, Vaishali Mahendra2, Susan M. Lee-Rife2

1International Center for Research on Women, United States of America; 2Independent Consultant; sleerife@icrw.org

Background/Significance:

Despite an increasing awareness of the role that gender norms play in fostering spousal communication, most behavior change strategies related to contraceptive promotion in India rely primarily on giving knowledge and information as a strategy to change attitudes and behaviors related to contraception. Fewer studies have explored how promoting gender equity, particularly among young men, can enhance their contraceptive behavior and related attitudes.
This paper describes preliminary results from one such experiment in rural parts of North India where men's participation in contraceptive use is particularly low.

Research Questions:
The main research questions for this study were, how can we best promote gender-equitable norms and behaviors among young men in rural India, and whether interventions focused on changing gender norms will improve spousal communication and enhance condom use by men with their regular partners.

Intervention and Methodology:
In rural areas of Gorakhpur, young men (ages 18 to 29) in one block of villages were exposed to group education sessions. The intervention was conducted over more than six months and involved 12-15 self-critical sessions on gender and masculinity led by peer leaders to help young men to redefine and reconstruct roles, responsibilities, and privileges. In another block of villages, another group of young men was exposed to an unrelated intervention for the same period. A survey was administered to the participants prior to the intervention (n=524 in the intervention arm and n=516 in the control site) and the participants were reinterviewed six months after the intervention (n=300 in the intervention site and n=301 in the control site). Attitudes towards gender norms was measured using Gender Equitable Men (GEM) Scale, and outcome variables included spousal communication on sex and sexuality including sexual pleasure, condom use, and knowledge and awareness about HIV/AIDS and sexually transmitted infections (STIs).

Findings:
Interventions were able to produce positive changes in gender attitudes across all the intervention groups in both urban and rural areas. There was a significant positive shift (p<.05) from the least equitable gender norm category to the moderate and highly equitable categories. In the intervention sites, more young men reported using condoms with their last sex partner as compared to the control sites. After the intervention, a fairly high percentages of men report that decisions on reproductive issues are taken jointly by both partners. Young men reported significant improvement in communication with their partners after the intervention on key reproductive and sexual health issues such as condom use, sexual pleasure, STIs, and HIV/AIDS. Results from logistic regression analyses for correlated data, controlling for key socio-demographic variables such as age, education, and occupation, indicate that contraceptive use is higher among young men who discuss and take joint decisions on contraception with their partners.

Knowledge Contribution:
Although the study was conducted within the larger framework of preventing HIV and reducing gender-based violence, findings suggest that the group education intervention had the greatest impact on key outcomes, and that including a gender focus in increasing inter-spousal/partner communication can be a successful strategy. This study has shown that the young men may be highly motivated to use contraception, if properly oriented towards gender issues.

P3: 12

Contraceptives Risk Perception and Sexual Negotiation in Marriage among Child bearing Rural Women in Southwest Nigeria
Ojo Melvin Agunbiade, Ayotunde Titilayo, Opatola Mustapha
Obafemi Awolowo University, Nigeria; ojomelvin@yahoo.com

Objectives: Effective use of modern contraceptives as a strategy to reducing the burden of maternal deaths in Nigeria may not yield optimum results if women associate the use of contraceptives with high risks and are unable to negotiate safe sex with their husbands. This study examined rural women views on modern contraceptives, their preferred choice of contraceptives, approaches in negotiating and protecting their sexual health within marriage.

Method: Three Vignettes based Focus Group Discussions sessions were held with child bearing women and those who claimed to have stopped childbearing in a Yoruba town.

Findings: Findings showed misconceptions with the use of family planning methods among the women. Many of them expressed fears in the use of contraceptives as they relied on unconfirmed experiences of other women on associated risks. Where choices of usage were made, more preference was expressed in pills and injections over other methods. Many of the women using contraceptives do so without their husbands' knowledge or support. This confirms unequal power relations between the women and their husbands in relation to the women's sexual health and rights. The fear of misconstruing their actions for promiscuity cut across the views of the categories of women interviewed.

Conclusions: More situational analysis of women's' social context will be necessary in scaling up efforts towards improving their sexual health and increasing the use of family planning methods among women in general.

P3: 13

Impact of Inter Spousal Communication on use of Modern Family Planning Methods in Nigeria
Samson Babatunde Adebayo, Chinazo Ujuju, Richard Fakolade, Jennifer Anyanti
Society for Family Health, Nigeria; sadebayo@sfhnigeria.org

Background
Reproductive health programs in Nigeria, have impacted on family planning (FP) knowledge, attitude and practice as factors that influence use of modern contraceptive methods. In patriarchal societies, male involvement is essential on vital decisions such as those relating to child spacing and use of contraceptives. In such a setting, inter-spousal communication becomes unavoidable.

Activity tested
This paper explores the influence of inter-spousal communication on use of modern family planning methods using a quasi experimental design among Women of Reproductive age (WRA).

Methodology
A quasi-experimental design survey was used to compare the level of knowledge, attitude and practice of WRA among those exposed to interventions with those of equivalent characteristics in the control communities. A multi-stage cluster sampling procedure was used. Based on appropriate formular and with the intention of detecting a 15% change in major indicators,

Data
A minimum sample size of 900 eligible respondents was obtained for each of the intervention and control communities giving a total sample size of 1,800 respondents for the survey. Bivariate and multivariate analyses were used to investigate the influence of inter-spousal communication on Contraceptive prevalence rate (CPR).
Findings
About 47.4% of the respondents who discussed family planning with spouse used a modern FP method compared with 27.8% who used modern FP among those who did not discuss FP with their spouses. This was very significant with a Chi-square value of $P<0.0001$. Adjusting for some covariates through logistic regression also showed a significant influence of inter-spousal communication on the use of modern FP method. Respondents who discussed FP method with spouse were about 2.8 times more likely to use a modern FP method compared with their counterparts who did not discuss FP with their spouses. Educational attainment, religion and age were also positively and significantly associated with use of modern FP method.

The Hosmer and Lemeshow Goodness-of-fit test showed a good fit between observed and the expected values ($P=0.376$). This implies that the model fits the data very well.

Lessons learnt
Effective inter-spousal communication on matters related to family planning is very crucial for the success of family planning programs. This can also enhance increased uptake and adoption of modern FP as a means of child spacing. Therefore, programmers will need to pay more attention to this and design appropriate intervention strategies on enhancing inter-spousal communication with the aim of increasing the use of modern family planning method.

P3: 14
A Study of Contraceptive Use Patterns Among Sexually Active Youths in Egbeda Local Government Area of Ibadan, Oyo State, Nigeria
Ranmilowo Titilope Jolaoso, Kayode Amusan, Toyin Ayeni
Obafemi Awolowo University, Nigeria; ranmilowow@yahoo.com

SECTION 22 - Contraception in relation to other proximate determinants of fertility.

BACKGROUND
Contraceptive use among sexually active youths have been documented to be low in Nigeria and there is a need to identify associated factors in order to plan appropriate intervention.

However, available evidence also suggest that the number of young people within this age group (15-24 years) in Nigeria who commenced pre-marital sexual relations has increased in the past few years.

OBJECTIVES: The objectives of this project were to determine the relationship between awareness of contraceptive before first sexual experience and contraceptive use, examine the perception of sexually active youths towards contraceptive use. The project also sought to determine the influence of sexual partner(s) on pattern of contraceptive.

METHODOLOGY: This study employed a cross-sectional design. A structural questionnaire was used to collect data from 350 Senior Secondary School Students in Egbeda Local Government Area of Oyo State using the multi state sampling technique.

The instrument measured Socio-economic and demographic characteristics of the respondents, sexual behaviour, contraceptive use among the respondents and perception of the youth towards contraceptive use. Data were analysed using SPSS and appropriate descriptive and inferential statistics were also used. Statistical Significant was placed at $P<0.05$.

RESULT: Results showed that a larger proportion of youth under th study fall within average ages of 17 and 19. There were more males(51.3%) than females(48.7%). Majority(73.1%) of the respondents were living with both parents and nearly all(99.5%) had boy or girl friends. All respondentDt had been sexually active. Less than fifty percent of the respondent had one sexual partner. About sixty percent of the respondent reported that they were aware of contraceptive. Sixty-six percent of them reported using contraceptive at their first sexual experience. Condom was the major form of contraceptive used.

More than sixty percent of the respondent reported that regular use of contraceptive prevent pregnancy and STDs ($P<0.05$) respectively majority(76.9%) of the respondent who had at most one partner reported never use any contraceptive method ($P<0.05$).

CONCLUSION:
Study showed that awareness of contraceptives before first sexual relationship, perception of likelihood of contracting sexually transmitted diseases and number of sexual partners have significant relationship with the contraceptive use patterns among the respondents. Also, condoms are the most used contraceptive methods by the youths.

P3: 15
Meeting the Family Planning Needs of Young Married Couples through the Private Health Sector: Evaluation of the Saathiya Youth Friendly Initiative in urban Uttar Pradesh
Aneesa Arur, Sara Sulzbach, Kathryn Banke
Abt Associates, United States of America; Aneesa_Arur@Abtassoc.com

1. Background/Significance
Sexually active youth present unique challenges to family planning (FP) programs in India because young women are typically expected to prove their fertility early in marriage. Although motherhood brings social status and respect, many young women lack information, decision-making power and access to family planning services, which would enable them to more safely plan their families (McCauley, 1995). Yet few programs have dealt with the special needs of sexually active youth (Van Rossum 2000, Agha, 2002).

The Commercial Market Strategies/CELSAM project in Mexico demonstrated the potential for targeting youth with family planning services through a youth friendly (YF) pharmacy initiative that combined training for pharmacists with a targeted communication campaign (Wolfe, 2005). Private Sector Partnerships-One (PSP-One), a USAID-funded project, seeks to test the potential impact of replicating key elements of this innovative program in urban India, where youth aged 15-24 represent 20% of the entire population in India (Registrar General of India 2001). While the average age at marriage has been increasing, a substantial proportion of the population is still married before the legal age of marriage (18 for women, 21 for men) (IIPS 2007; Futures Group 2005) making this an important target group for FP programs. PSP-One launched the Saathiya Youth Friendly Initiative (YFI) in Lucknow, a North Indian city, in November 2007.

2. Research: State main question/hypothesis
Program: State intervention/activity tested
Meaning “trusted partner”, Saathiya targets married youth (15-24 for women and 20-29 for men) belonging to the middle three socio-economic groups (‘B’, ‘C’ and ‘D’). However, there are no restrictions embedded in the program to prevent unmarried youth from accessing Saathiya YFI services. Saathiya YFI has a multi-faceted focus on the retail environment, health providers and demand generation and includes the following elements:

- Intensive training training on technical and interpersonal communication with youth for chemists, Indian Systems of Medicines practitioners and medical doctors. These trained providers form a ‘Saathiya’ network of providers.
- Saathiya YFI supports networked providers with advertising and outreach promoting the Saathiya brand, including via in-clinic or in-store promotional materials and retail signage.
- Basket of modern and reversible branded contraceptives promoted and available through Saathiya providers.
- A toll-free telephone helpline with trained counselors to provide FP information, counsel callers and refer callers to Saathiya providers where appropriate.

Given our concern with increasing access to FP for youth in urban India, our main research hypothesis is:

Combined implementation of targeted communication interventions and providers trained in YFI family planning services leads to an increased use of family planning among youth exposed to the Saathiya YFI interventions compared to youth that have not been exposed to Saathiya YFI interventions.

3. Methodology (including location, setting, period, analysis approach)

We employ a difference-in-differences methodology to ascertain the impact of Saathiya YFI on FP knowledge, attitudes and practices among married youth. Lucknow city, in Uttar Pradesh state of North India is the intervention area. Kanpur, a city in Uttar Pradesh with similar characteristics serves as a comparison.

\[ DD = (Y_1 - Y_0i) - (Y_1 - Y_0c) \]

Where

- DD: Difference-in-Differences or Double Differences
- \( Y_1 \): Outcome variable at endline, i.e., post-Saathiya YFI
- \( Y_0 \): Outcome variable at baseline, i.e., pre-Saathiya YFI

I: Intervention group in Lucknow

C: Comparison group in Kanpur

We will examine alternative explanations to the observed changes, and if they can be ruled out we will argue that the observed improvements in FP variables may be effects of Saathiya YFI intervention.

4. Data (if relevant)

Data are obtained through two cross-sectional surveys in Lucknow & Kanpur: a pre-intervention household survey in June 2007 and a post-intervention survey that commenced in Apr 2009 and is near-complete. Both baseline and endline included currently married men (20-29) and women (15-24) living in households in the catchment area—400-500 meter radius—around Saathiya YFI network providers selected through a stratified random sampling scheme. A total of 2,573 interviews were conducted in the baseline (n=1,152 in Lucknow and n=1,421 in Kanpur). A total of 2,784 interviews have been completed at the endline (n=1,395 in Lucknow and n=1,412 in Kanpur).

In addition, providers sampled at endline (n=137) were included in a brief survey to assess FP knowledge and the availability of Saathiya YFI-related inputs at their facilities.

5. Findings

6. Research: State knowledge contribution

Program: State lessons learned

Baseline data analyses showed that only 44% of men and women between 20-24 are current FP users. Over 80% of current users rely on the private sector. This suggests that an evaluation of a strategy to provide youth friendly FP services through a private sector network could help to increase FP use among youth.

Comparative results are not yet available as the full endline dataset will be available in early June 2009. It is anticipated that the results will advance FP practice by presenting strong empirical evidence on a potentially promising strategy to meet the FP needs of sexually active youth in India, and possibly to other developing countries.

P3 16

**Persistent high fertility in Uganda: Young people recount enabling factors and obstacles to use of contraceptives**

**Gorrette Nalwadda**

Makerere University, College of Health Sciences, Uganda; gnalwadda@gmail.com

Title: Persistent high fertility in Uganda: Young people recount enabling factors and obstacles to use of contraceptives

Nalwadda Gorrettel, 2, 3, Mirembe Florence 2, Byamugisha Josaphat 2, Faxelid Elisabeth3

1 Department of Nursing, School of Health sciences, CHS Makerere University, Uganda P.O.Box 7072, Kampala,

Tel: 256 414 530404

2 Departments of Obstetrics and Gynecology, Makerere University, Uganda

3 Division of Global/international health (IHCAR), Karolinska Institutet Sweden

**Abstract**

Background/Significance: High fertility observed among young people 15-24 years who constitute 33 percent of Ugandan population is a public health concern. High teen pregnancy, unintended birth, un-safe induced abortions and associated mortality among young people, is attributed to low contraceptive use. Mean time the bio-social gap that is the period between menarche and marriage has widened, hence the amount of time young women/men need contraception has increased dramatically. Paradoxically, knowledge on contraceptive use is high but utilization is low. It is not understood why young people are not using contraceptives, hence this study. Culturally sensitive recommendations and strategies evolved from study.
Objective: The study explored young people’s views about obstacles and enabling factors to contraceptive use in two districts in Uganda.

Methodology: Sixteen focus group discussions were conducted with married and unmarried male and female young people aged 15-24 years in urban and rural areas in two districts, Mityana and Mubende. Qualitative content analysis was used to analyze the data.

Findings: Obstacles included ingrained misconceptions about methods of contraceptives; over weighted burden of side effects and belief that side effects are permanent; confusion between side effects and misconceptions fear of side effects. Young men and women were more fearful of pregnancy than HIV/AIDS and other diseases. Other emerging societal perceptions discovered were building trust in partner much earlier resulting in abandoning condoms, much early sexual initiation, and early pregnancy as a marriage incentive as well as premarital sex not being a problem anymore all negatively affects use. Social cultural norms that suppose women’s purpose is child bearing and the belief in many children weaken women capability to negotiate for use. Furthermore, women would not insist on contraceptive use for fear of being stigmatized as sexually experienced. Women’s lack of power in relation to men and lack of decision making power is a major obstacle to use. There was negative peer pressure and rumors especially among male participants further compromising negotiations to use. Contradictions particularly from male partners, parents, society-church, schools, and health units that have taken divergent positions in favor and against use result in mixed messages on contraceptives; more still health service barriers exist.

Enablers to use of contraceptives built-in conviction and secrete use; female discussants found it difficult to discuss use of contraceptives with partners thus resorted to using in secret. Male counterparts revealed fear of imprisonment if made a young girl pregnant. Awareness of methods was high in both male and female participants. Changing perceptions and behavior of young people re-counting desire small family, fear abortion following unwanted pregnancy were elucidated as enablers to use of contraceptives.

Knowledge Contribution or Lessons Learned: Gender and power relations and low risk perceptions, misconceptions and contradictions affect contraceptive use. Changing perceptions, conviction and secrecy enabled use. Obstacles, using enabling approaches can be transformed into prospects or opportunity to use of contraceptives. Misconceptions have implication for the amplification of alternative models of delivery of contraceptives to control fertility

Key words: changing perceptions, young people, contraceptive use, obstacles, enabling factors/approaches

P3: 17

Access to Youth-Friendly Reproductive Health Services in Georgia

Tamar Khomasuridze, Lela Bakradze, Tea Jaliaishvili
United Nations Population Fund (UNFPA), Georgia; khomasuridze@unfpa.org

1. Background/Significance

For Georgia the turbulent period of early independence after the break of the Soviet Union in 1991, resulted in bloated of both infrastructural and human resource capacity far beyond the country’s needs. Civil war, displacement of people, subsequent lack of financial resources and the economic crisis the country have had the impact on depopulation, aging, fertility rate, and resulted in sharp reduction of birthrate and dropping of natural growth. The RH status of population became the concern due to limited access of population and particularly youth to quality RH info and services. Reproductive health services were female oriented maternal consultations and not confidential. Also lack of men involvement in reproductive health issues and the limited access to reproductive health information and services were area of concern.

To address the needs and reproductive health concerns of the Population in Georgia UNFPA started its assistance after Cairo Conference. UNFPA supports the Georgian Government in the implementation of the ICPD Program of Action and MDGs, which lays the foundation towards the improved reproductive health, poverty reduction and economic empowerment of the population.

Based on assessments and surveys on youth needs conducted in 2002 and 2005 the lack of access to youth – friendly reproductive health services revealed. Youth-friendly health services are an important step to ensure youth access to information and services regularly and easily in supporting youth S&RH and Rights. Also lack of men involvement in reproductive health issues and the limited access to reproductive health information and services are important areas of concern. The UNFPA and Georgian Government agreed strategy on youth-friendly services covers topics related to capacity building of Service providers, to improvement the structures and conditions of the Health facilities and youth participation in Programme design and monitoring. Provision and proper functioning of youth friendly services in Georgia will have an important positive impact on youth S&RH and right

2. Main question/hypothesis: Are youth-friendly services easily accessible for youth in Georgia.

3. Methodology:

• In-depth Interviews – based on the specially elaborated questionnaire
• Besides the assessments based on information obtained from the questionnaire (physical and financial accessibility of RH/SH services, confidentiality and privacy and etc.) five different scenarios have been developed in order to determine the quality and adequacy of medical care and consultations. Specially trained interviewers visited RH/SH services according to these scenarios and applied different above-mentioned scenarios. After the visit the interviewers were answering specific questions that were especially prepared for each of scenarios

Findings:

• Youth - friendly Reproductive Health Information Centers are the best option for awareness raising and knowledge improvement for young people on S&RH and Rights
• Youth - friendly Reproductive Health Medical Centers are most effective on primary health care level
• For provision of youth friendly services multidimensional approach is needed. Efforts should be focused on improved education and raised awareness of young people on youth reproductive health and rights, also capacity building for medical personnel on S&RH issues, improved access to youth friendly medical/information centers and partnership with private and public sector.

P3: 18

Mobilizing Married Youth in Nepal to Improve Reproductive Health

Manisha Mehta, Theresa Castillo
Engender Health, United States of America; mmehata@engenderhealth.org

1. Background/Significance
Almost one-third of Nepalese women aged 15–19 years are married, and more than two-fifths of women are already mothers or pregnant with their first child by 19 years of age, but access to family planning and maternal health services is extremely low. Among women under 20 years of age, only 9% have ever used a modern method of contraception and only 22% of births were delivered by a skilled birth attendant.

The ACQUIRE Project implemented a pilot project—the Reproductive Health for Married Adolescent Couples Project (RHMACP)—from 2005 to 2007 within two districts of Nepal. RHMACP utilized an ecological model to improve health outcomes for married adolescents by implementing comprehensive interventions that engage individuals at risk of poor health outcomes. These interventions also targeted family and community members, health care personnel and policy makers, and the social norms, beliefs, and systems that impact health practices within communities.

2. Research: State main question/hypothesis
Program: State intervention/activity tested
The project aimed to achieve the following three objectives:
1. Increase married adolescents’ knowledge about family planning, maternal health, and HIV and sexually transmitted infections
2. Increase health service providers’ knowledge about the reproductive health needs of married adolescents, to improve married adolescents’ access to quality health services
3. Increase community and family support for reproductive health decision making by married adolescent couples

Primary targets of the project were married women below the age of 20 years and their husbands. Secondary targets included service providers, influential community members and family members, and youth under 25 years of age.

3. Methodology (including location, setting, period, analysis approach)
Impact was measured through baseline and endline surveys using household surveys structured after the Demographic and Health Surveys model. The sample size for both surveys was 960 married individuals—480 for each sex and 480 for each district. A 30-cluster sample of village development councils (VDCs) was generated from the 69 project VDCs. Baseline and endline surveys used the same clusters, with resampling of respondents from VDC household listings. Male and female respondents were selected from alternate households, and an equal number of respondents (16 males and 16 females) were interviewed from each sample VDC.

4. Data/Findings
The percentage of married adolescents visiting government health facilities for services rose from 36% in 2005 to 42% in 2007, and the percentage of female adolescents who made four or more antenatal care visits during their last pregnancy increased significantly, from 29% to 50%. The proportion of young married women who delivered with the help of a skilled birth attendant also rose, from 24% to 31% over the two-year period, and the proportion of deliveries taking place at home fell, from 75% to 67%.

Adolescents’ awareness of two or more modern methods of contraception, as well as their knowledge of where to obtain contraceptives, was almost universal at endline. Awareness of oral contraceptives among male adolescents rose from only 4% to 84%. The awareness that condom use can prevent pregnancy rose significantly among women (from 65% to 93%) and also increased among men (from 90% to 98%). The acceptability of a woman’s insisting on condom use with her partner increased from 72% to 80% among men and from 51% to 72% among women. At endline, 65% of female adolescents and 79% of males considered that a husband and wife together were responsible for family planning decisions, up significantly from 37% of women and 57% of men at baseline. These findings indicate greater potential for informed choice of contraceptives, especially among young women.

Use of contraception before first pregnancy remained low, however (only 4.8% among female respondents and 11.3% among male respondents), and no delay in childbearing was recorded. Despite evidence at the endline that more than 97% of married adolescents perceived that postponing the first birth reduced health risks to the mother, the median age at first birth remained at 17 years (which is not surprising given the difficulty in changing entrenched norms around childbearing).

The median age at marriage rose from 14 to 16 years (a statistically significant increase), while median age at gauna (the local custom when a married girl moves into her husband’s home following menarche, for consummation of the marriage) rose from 15 to 16 years.

5. Research: State knowledge contribution
Program: State lessons learned
To achieve major changes in individual behavior and social norms, and for systemic improvements in health provision, a two-year pilot intervention is extremely short. However, with a multilevel implementation strategy, it is possible to achieve normative change. More intensive targeting of influential family and community members is needed to affect cultural beliefs and behaviors that negatively impact youth reproductive health decision making and outcomes.

Experience from the intervention further suggests that the model would be applicable to health, development, and governance initiatives in diverse country settings.

P3: 19

How Spousal Communication Affects Family Planning Knowledge and Use in Central Terai, Nepal
Carolyn O'Donnell1, Laurette Cucuzza2, Dale Davis2, Plush Kayastha2
1Center for Development and Population Activities (CEDPA), United States of America; 2Center for Development and Population Activities (CEDPA), Nepal; codonell@cedpa.org

Background/Significance:
Currently, 44% of married Nepali women use modern contraceptive methods and the total fertility rate has declined from 4.1 in 2001 to 3.1 in 2006. However, poor and socially excluded ethnic groups frequently do not access family planning services, despite the fact that the government is now prioritizing these groups through its policies. Cultural norms promote early marriage and motherhood, leading to increased risks for neonatal complications at delivery and high maternal mortality.

A study on spousal communication and contraceptive use in Nepal shows that couples who view family planning favorably are more likely to communicate about the number and spacing of their children, and tend to adopt contraceptive methods (Sharan et al, 2002). Although this study did not analyze whether spousal communication was associated with contraception adoption, results show that discussion with husbands on FP was relatively high across districts.
Research: Main question/hypothesis
Given the possible correlation between spousal communication and contraceptive use, CEDPA’s research seeks to determine whether improved spousal communication increases contraceptive use among married women of child-bearing age in Nepal.

Program: Intervention/activity tested
CEDPA Nepal’s 2007-2009 Family Future Project aims to increase use of modern contraceptives among married women of reproductive age (MWRA) and youth (ages 13-24). The program is implemented through three local partners: Gramin Utthan Abhiyan in Bara, Environment and Child Development Council in Rautahat, and Nepal Red Cross Society with Gramin Dalit Samaj in Sarlahi.

The project expands community-level access to FP/RH services among disadvantaged groups through volunteer Peer Health Educators (PHEs) and Future Family Supporters (FFSs). To date, 162 female and 108 male PHEs have conducted discussions on FP/RH/ HIV/AIDS with 810 peers, and have facilitated 90 weekly peer discussion groups. Men targeted in program outreach are instructed to communicate information to their wives, which is an additional channel for increasing contraceptive use among MWRA.

Methodology (including location, setting, period, analysis approach):
Quantitative data from a baseline and follow-up survey (2007 and 2009), supplemented by qualitative interviews and focus groups, will be used to examine contraceptive rates among married women in Central Terai. Repeated measures (Linear Mixed Modeling) in SPSS software will be used to identify significant changes in key programmatic outcomes, such as contraceptive usage and barriers to family planning. The evaluation will focus on changes in contraceptive use based on perceived quality of spousal communication, frequency of FP discussions and involvement of husbands in FP decisions.

Data:
CEDPA’s questionnaires were adapted from USAID’s Flexible Fund prototype. A two-stage stratified cluster sampling approach was used to identify the 946 MWRA who completed the baseline survey (and will complete the endline survey). Conducted in the 27 Village Development Committees, the survey asks about FP knowledge, attitudes, and practices among married women of reproductive age.

Findings:
Baseline results confirmed the widespread practice of early marriage: 82% are married before the legal age, and 54% of women were pregnant by age 18. Unmet need for family planning was 27%. Muslims, Dalits and other severely marginalized groups reported difficulty in accessing information, and experienced the greatest barriers to accessing services. The findings clearly confirm the need to address cultural and religious issues, and to strengthen communication from health providers.

Baseline findings show that 38% of women consider family planning decisions shared between herself and her husband, 30% consider it the husband’s decision, and 20% believe it is the woman’s choice. Results also show that 62.6% of women who have ever discussed family planning with their husbands currently use some form of family planning; only 18.6% of women who have not discussed it use a contraceptive method. Fifty-one percent of women who know how many children their husbands want use family planning, while about 42% of women who do not know this information use family planning. We expect endline results to show an increase in the proportion of women who discussed family planning with their husbands in the last twelve months in addition to increased contraceptive prevalence rates.

Program: State lessons learned
We expect to learn how FP information is shared between spouses and whether spousal communication affects FP uptake and knowledge from comparative baseline-endline results, which will be completed by September (the endline survey will be administered in July 2009). We hope to identify strategies to maximize communication in future programs.

A06: Men and Family Planning II

Time: Tuesday, 17 November 2009: 11:30am - 1:00pm

A06: 1

Factors that Influence Male Involvement in Sexual and Reproductive Health in western Kenya: a Qualitative Study
Monica Adhiambo Onyango1, Sam Owoko2, Monica Atieno Ogotu3
1Boston University School of Public Health, United States of America; 2Kisumu Medical and Education Trust, Kenya; 3Kisumu Medical and Education Trust, Kenya; monyango@bu.edu

1. Background/Significance:
Traditional reproductive health programs almost exclusively focused on women. The popular view about men’s participation and involvement in family planning for example has been that men know little about contraception and do not want their partners to use it.

Kisumu Medical and Education Trust (K-MET) a Kenyan non governmental organization has been implementing community based reproductive health programs for over 13 years in five provinces of Kenya. One of K-MET’s objectives is to enhance the involvement of up to 400 male partners in sexual and reproductive health (SRH) services by 2010 in Western Kenya.

This abstract represents part of findings from a qualitative study which explored the best strategies for involving men in SRH in western Kenya. The specific objectives are:
1. To identify the factors that influence male involvement in SRH in western Kenya;
2. To establish the best strategies to involve men in SRH in western Kenya.
3. Hypothesis Tested
This was a qualitative descriptive study and did seek to test a hypothesis. It explored the best strategies to involve men in SRH in western Kenya

3. Methodology:
The study was conducted using qualitative descriptive (QD) design. Data was collected from December 2008 to February 2009 at three provinces of western Kenya: Nyanza, North Rift and Western. Study locations were mapped around five health facilities run by private health providers within the post-abortion care network (PACNET) of western Kenya.
A06:}

You started using family planning, what does he think? A study of men’s influence on contraceptive continuation in Nyando District, Kenya

Holly Burke, Constance Ambasa-Shisanya
Family Health International, United States of America; Dshattuck@fhi.org

1. Background/Significance
For hormonal contraceptive methods to be effective, women must continue using them. Discontinuation of contraception is a problem in Kenya. Depot medroxyprogesterone acetate (DMPA) is the most popular method in the country, yet 20% of women discontinue this highly effective method within 12 months of beginning use, mainly due to side-effects. While most research has focused on user and method-related characteristics associated with discontinuation, little attention has been paid to the influence of other people, in particular men, on discontinuation.

In 2007-2008, we conducted focus group discussions (FGDs) with current DMPA users to identify their salient references—those people who influence women’s use and discontinuation of contraception. Husbands and male community leaders emerged as important salient reference groups. Subsequently, we conducted FGDs with both of these groups to determine how they influence women’s continued use of contraception in this community. This formative research was part of a larger effort to develop appropriate messages for a community-wide communication campaign to increase contraceptive continuation among DMPA users in Nyando District, Kenya.

2. Research: State main question/hypothesis
To identify why some men encourage discontinuation of DMPA among current users in Nyando District, Kenya.

3. Methodology
Eight FGDs were conducted; four with husbands of women using DMPA and four with community leaders. Participants were purposively sampled and recruited with the help of staff at family planning clinics and DMPA users in Nyando District, Kenya. The community leaders, who were primarily male, included village chiefs, assistant chiefs, village elders, religious leaders, and community health workers. Each FGD contained 8-11 participants and took 1-2 hours to complete. The discussions were conducted in the local language (Dholuo), tape recorded, and covered the following topics: contraceptive decision making processes, family planning information seeking behaviors, words used to describe family planning and contraceptive methods, likes and dislikes of DMPA, reasons for discontinuation of DMPA, and the best way to communicate messages designed to facilitate continuation of DMPA.

4. Data
The tape recorded FGDs were transcribed and translated from Dholuo into English onto computer files. Raw text data in the form of transcripts were coded using QSR International’s NVivo 7 software. A detailed codebook was developed by two researchers where themes were identified and defined. Using a grounded theory approach, some codes were predetermined, but most of the codes were generated during the reading of the transcripts. Reports were generated using the software to identify patterns in the themes (i.e., which codes clustered or separated out) and to sort the coded data (i.e., collect similarly coded blocks of text). Based on these reports, evidence supporting each theme was examined both quantitatively (i.e., frequency of phenomenon) and qualitatively (i.e., specific vocabulary used and context).

5. Findings
In Nyando District, Kenya, men reported that they had strong influence over women’s decisions to continue using contraceptive methods. Husbands reported they would want their wives to stop using DMPA if they feared it physically harm their wives, they wanted more children to compete with neighbors or to name children after deceased relatives, and for religious reasons. Male community leaders reported that they encouraged discontinuation of DMPA because they feared method use would result in deformed children; they wanted to increase the community size for political reasons, and for religious reasons. Both groups
of men had a low level of knowledge regarding side effects of hormonal contraceptives, especially DMPA. However, most of the men were eager to learn about contraceptive methods and said they would like to be included in family planning interventions.

6. Research: State knowledge contribution

This study identified areas of intervention for increasing contraceptive continuation in a resource-poor setting. Husbands and male community leaders reported that they had strong influence over women’s decision to continue using contraception. But they also lacked accurate information about the side effects of DMPA. The results suggest that efforts to increase contraceptive continuation should target men with accurate information about side effects and dispel myths about DMPA. Influential groups of men in the community, including religious leaders, should be included in a meaningful way in interventions aimed at increasing contraceptive adoption and continuation.

These findings were used to inform a communication campaign aimed at increasing contraceptive continuation among DMPA users in Nyando District. As part of the campaign, radio spots and posters were developed to target husbands and community leaders with messages based on the findings from this study. The campaign aired April 2009 in Nyando District with evaluation results expected in 2010.

A06: 3

Using Male Educators to Increase Family Planning Uptake among Young Couples: The Malawi Male Motivator Project

Dominick Shattuck1, Brad Kerner2, Katherine Gilles3, Joshua Murphy4, Thokozani Ng’ombe5, John Bratt6, Greg Guest7

1Family Health International, United States of America; 2Save the Children; Dshattuck@phi.org

1. Background/Significance

The 1994 International Conference on Population and Development in Cairo shed light on incorporating men in reproductive health services as a means to improve the reproductive health of women and men. Since Cairo, many organizations have begun advocating for male involvement in reproductive health services, opposing traditional views that such services will detract from resources targeting women. In Sub-Saharan Africa, male involvement in reproductive health programming is crucial since men are often the primary decision makers about family size and their partner’s use of family planning methods.

The need to enhance family planning uptake in Malawi is substantial. The country has a high fertility rate (6.34), and despite tripling of modern contraceptive use since 1992, the country’s contraceptive prevalence rate is currently only 26%. Young people in Malawi are particularly in need of family planning information. The country is characterized by high rates of early marriage and pregnancy (1/3 of women between 15-19 years old are mothers or have been pregnant), low use of contraception by young people (7.6% of women ages 15-19 years old are currently using a modern method) and a high, unmet need for family planning among married women (26.1%) and unmarried women, ages 15-19.

According to Demographic & Health Survey data from 2004 for Malawi, the most commonly reported female controlled contraceptive used among women ages 15-19 is injectables (11.8% for married and 9.2% for unmarried and sexually active). Reported condom use in this age group is extremely low (3.4% for married and 14.3% for unmarried sexually active). This same report indicated that over one-third (36.5) of married women 15-19 years old had never talked to their husbands about family planning. A positive connection between inter-spousal communication and contraceptive use was identified for initial use and over time.

Today’s programs targeting men must focus on educational messages which explore the economic side of limiting births and improving the family’s standard of living, since men are more likely to be convinced by arguments based on economics, or other socio-cultural factors, rather than maternal-child health alone.

2. Program: State intervention/activity tested

The Malawi Male Motivator project, a peer-delivered educational intervention oriented specifically towards men was implemented and assessed in the Mangochi province of Malawi. The intervention focused on cross generational marriages by targeting husbands through a male peer outreach worker, referred to as a Male Motivator. Five educational visits from a “Male Motivator” were conducted over a 6-month period with the participating men. The curriculum explored traditional gender norms and how these norms affect poor health outcomes and the underutilization of family planning methods.

3. Methodology (including location, setting, period, analysis approach)

Three hundred ninety-seven men from the rural villages surrounding Mangochi, Malawi were randomized into treatment and control arms to assess this intervention [289 at post intervention: 149 treatment, 140 control]. Men identified for this study reported not using any form of family planning method at recruitment. Rural villages were used because of the higher proportion of younger, less educated, and more vulnerable married women residing in these areas. A mixed methods approach was implemented which utilized pre-post quantitative survey administration and 14 in-depth interviews with men in the treatment group. The quantitative survey encompassed the following family planning focused constructs: knowledge, attitudes, self-efficacy, communication, and equitable gender norms. A cost analysis of the intervention was also conducted.

4. Data and Findings

After the intervention, contraceptive use differed significantly between the two groups: Intervention 78%, Control 59% (p < .01). Quantitative and qualitative data indicate that: within-group increases in family planning knowledge, attitudes, self-efficacy, and equitable gender norms (p < .05). Communication within couples influenced uptake (p < .01). Condoms were the most frequently selected family planning method, and selection of method was based on ease of use and limited number of side-effects. Qualitative findings supported the changes mentioned above and indicated that the intervention was well received by participants.

5. Research: State knowledge contribution

To our knowledge, this study is the first to evaluate the effectiveness of the Malawi Male Motivator project, a family planning intervention that targeted men and utilized economic and health related outcomes associated with the implementation of family planning. A mixed methods approach was used to statistically support the conclusions and provide clear understanding of the perceptions of the participants. The skill of communicating about family planning was developed through this intervention and identified as a related variable in the uptake of family planning methods. Also, significant increases in family planning uptake were identified in both the treatment and control groups. Two theories Diffusion of Innovations and the Question Behavior Effect were identified as possible explanatory theories for this increase. Research results will be disseminated to NGOs and government leaders in Malawi and may inform the replication of this intervention and the methods used to assess its effectiveness.

A06: 4

Myths and Misinformation, Factual Information, Discussion about Family Planning and Contraceptive Use in Nigeria

Muyiwa Oladosun1, Jennifer Anyanti2, Augustine Ankomah3

1MiraMonitor Consulting Ltd., Abuja, Nigeria; 2Society for Family Health, Abuja, Nigeria; 3Population Services International, Nairobi, Kenya; fs0226@yahoo.com

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Background:
Family planning program efforts started in Nigeria over 30 years ago. Since then, public legitimacy and the environment for contraception has improved due largely to government support and donor funding. What has not improved significantly is contraceptive use among sexually active peoples in the country. The literature suggest sociocultural barriers inhibiting massive use of contraception methods since latent demand is evident from past surveys.

Hypothesis/Intervention:
This paper examined myths and misinformation, factual information, discussion about family planning, sexual behavior, and background factors influencing contraceptive use in Nigeria. The objective was to provide information on key predictors of contraceptive use over a four-year window with focus on barriers to use for men vis-à-vis women.

Data and Methods:

Findings:
Findings showed that men had more myths and misinformation than women. The only significant myth and misinformation that had negative effects on the contraception behavior of women was that family planning leads to infertility in women. The myths and misinformation that had negative effects on men’s contraception behavior were that family planning (FP): (1) make unmarried people promiscuous, (2) expensive to practice, (3) women’s business and not for men, and (4) that it leads to infertility in women. Factual information that had positive effects on contraceptive behavior of both men and women were: methods are effective, methods protect a woman from unwanted pregnancy, religion is not against FP, and unsafe abortion prevents women from having children. Discussions with spouse and with a health worker were two effective means of providing FP information to the studied population. The effects of factual information about family planning to change in behavior may have been attenuated by myths and misinformation.

Knowledge Contribution/Lessons Learned:
Programming should focus on eliminating myths and misinformation, while strengthening access to factual information in Nigeria. Also, program efforts should consider the role of the significant others in people’s lives, and design activities to reflect diverse background characteristics of respondents.

A06: 5

Male Partner’s Roles in Women’s Use of Emergency Contraception
Kelly L’Engle, Dawn Chin-Quee, Michele Lanham, Laura Hinson, Heather Vahdat
Family Health International, United States of America; Dishattuck@fhi.org

1. Background/Significance
Emergency contraceptive pills (ECPs) are pills taken after unprotected sex to reduce the risk of pregnancy. Several studies in sub-Saharan Africa have found that awareness and knowledge of ECPs is low, although obtaining ECPs from private sector pharmacies is increasing and ECPs appear to be gaining popularity among sexually active young adults.

Men may play an important role in their partners’ use of ECPs. Anecdotal evidence shows that anywhere from 10-50% of clients purchasing ECPs in sub-Saharan Africa are men. In Ghana, the sale of ECPs is highly acceptable to both men and women. Little is known, however, about who these men are, their motivations for purchasing ECPs for their partners, or what other roles they may play in their partners’ ECP use. However, increased understanding of men’s roles in women’s use of emergency contraception may have important public health implications for promoting EC and other contraceptive methods, including condoms. Prior research has shown that women are more likely to use contraception if men are involved in the decision and supportive of it.

2. Research: State main question/hypothesis
Program: State intervention/activity tested
To describe the characteristics of men who support women’s use of emergency contraception, and to learn how and why men influence women to use emergency and other contraception.

3. Methodology (including location, setting, period, analysis approach)
This study included men who influence women to use ECPs in the following ways: (1) Men buy ECPs for female partners; (2) Men influence female partner’s ECP use in instrumental ways (e.g., provide money for ECP purchase or transportation to pharmacy); or (3) Men tell or encourage a female partner to use ECPs. In May-June 2009, approximately 250 men who met at least one of these criteria were recruited from pharmacies in Accra, Ghana to complete a survey about their ECP knowledge, attitudes, and roles in female partners’ ECP use. Men were also recruited from pharmacies for 30 in-depth interviews to gain further insights into these issues. Quantitative analysis focused on describing the characteristics of men who support women’s ECP use, and qualitative analysis highlighted how and why men influence women to use ECPs.

4. Data and Findings
Survey data showed the median age of male “ECP influencers” was 28, two-thirds were single, and more than one-third had completed university. The large majority of men used ECPs with partners who were in their 20’s, typically because they did not use any method to prevent pregnancy at the time. Three-quarters of male respondents reported having sex at least two times per week on average, and in addition to ECPs they sometimes used male condoms, withdrawal, and fertility awareness for pregnancy prevention. Although knowledge of how to use ECPs was high, most men believed ECPs are equally effective for pregnancy prevention as oral contraceptive pills, and a number of men were unsure whether ECP was an abortifacient.

In line with the survey data, the large majority of in-depth-interview participants were in their 20’s and single. The majority of qualitative participants bought ECPs for their partners or gave partners money to buy it, largely to ensure that partners would take the pills and remember to take both pills in the ECP regimen. They also frequently introduced their partner to ECPs. Participants felt men should take an active role in family planning with their partners, including reminding their female partners to take their ECPs and knowing their partners’ menstrual cycles.

The in-depth interviews also confirmed findings from the quantitative survey about the contraceptive method mix of ECP users, in that participants reported using ECPs as well as condoms, withdrawal, and fertility awareness. The qualitative data showed that ECPs were most likely to be used when men had unprotected sex with a woman during the time she was perceived to be most fertile. Qualitative participants believed that ECPs are highly effective for pregnancy prevention, often stating that ECPs are more effective than other methods. However, male participants had very little awareness of other hormonal
contraceptive methods. Barriers to oral contraceptive pill (OCP) use were mentioned by several men, including the belief that daily pill taking is stressful and that it is difficult for women to remember to take a daily pill.

5. Research: State knowledge contribution

To our knowledge, no data have been collected systematically from men regarding their support of women’s ECP use. In this study, we used a mixed-method research design to learn about men’s roles in women’s use of emergency contraception. It is anticipated that research results will be disseminated to government and NGO stakeholders in Ghana and findings from this study may inform service delivery protocols and the design of IEC materials as indicated. For example, ECP users clearly need information about other modern contraceptive methods and a better understanding of the effectiveness of ECPs in comparison to other methods.

B06: Contraception and Abortion I

**Time:** Tuesday, 17 November 2009: 11:30am - 1:00pm

**B06: 1**

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


1Bixby Center for Population, Health, and Development, University of California, Berkeley; 2Venture Strategies for Health and Development, United States of America; 3School of Public Health, Addis Ababa University, Ethiopia; 4Venture Strategies for Health and Development/DKT Ethiopia, Addis Ababa, Ethiopia; mholston@venturestrategies.org

**Background:** Characteristic of most of sub-Saharan Africa, fertility in Ethiopia is high (5.4) nation-wide, close to one third of births are either mistimed or unwanted, and there is a huge unmet need (34%) for family planning. However, Ethiopia has changed its abortion laws in 2005, and Addis Ababa is unique in particular for having below-replacement fertility. While the services outlined in the guidelines developed by the Ministry of Health are not widely available throughout the country, safe abortion services in Addis Ababa are fairly accessible in both public and private facilities.

**Activity Tested:** The purpose of this paper is to examine the patterns of contraceptive use among women seeking repeat abortions. This information will help to characterize the access of family planning services of women that want to limit or space childbearing and will help redesign services to meet the needs of these women with the goal to reduce repeat abortion.

**Methodology:** We conducted a secondary data analysis of client records of 1,200 women receiving safe abortion or post-abortion care from October 2008 to February 2009 in three public and three private health facilities in Addis Ababa, Ethiopia. Among these women, 363 (30%) sought a repeat abortion, which we defined as having one or more previous induced termination of pregnancy. We compared the socio-demographic characteristics, gynecological and obstetric history, and use of contraception between women coming for their first versus repeat abortion. In addition, we interviewed five service providers directly involved in abortion service delivery to gain their perspective on contraceptive use among women seeking abortion-related services, especially those seeking repeat abortion.

**Findings:** The socio-demographic characteristics of women seeking a repeat abortion differed from women coming for their first abortion. Women who had a previous abortion were older (26.1 vs. 24.7 years), more likely to be married (48% vs. 39%), and reside in Addis Ababa (95% vs. 90%), and have secondary education or above (79% vs. 73%) than women attending the facility for their first abortion. While housewives/unemployed were equally likely to be having their first or repeat abortion, students were more likely to be coming for their first abortion (18% vs. 10%), and women who were employed in professional/clerical positions were more likely to have had a previous abortion (40% vs. 34%). Women coming for a repeat abortion had an average of 1.3 previous abortions.

Women who had previous abortions were more likely to have ever used contraceptives (69% vs. 51%) than women coming for their first abortion. Ever use of short-term reversible modern methods, such as contraceptive pills and condoms, were more prevalent among women coming for a repeat abortion (47% vs. 29%) than women coming for their first abortion. After adjusting for socio-demographic characteristics and gynecologic history, women coming for a repeat abortion were 50% more likely to have ever used family planning (OR 1.4, 95% CI 1.0-2.0). Most women were provided a contraceptive method post-abortion (78%). Women coming for a repeat abortion were more likely to be provided post-abortion contraception (71% vs. 76%) than women coming for their first abortion. After adjusting for socio-demographic and gynecologic characteristics, women coming for a repeat abortion had twice the odds of being provided a contraceptive method at the time of service, (OR 1.9, 95% CI 1.4-2.5). Again, women who had a previous abortion were more likely to choose short-term reversible methods (56% vs. 48%).

Providers cited lack of awareness, negligence, and dependence on abortion for non-use of family planning among women seeking abortions. All reported that family planning use is more common among older and married women, and contraceptive use among the young is very low and inconsistent. Most mentioned that repeat abortion is common; one provider said it was very common for a client to come in three or four times seeking an abortion. Providers said that women coming for repeat abortions were “negligent” in using contraceptives, and reported that there were failures due to incorrect use of pills and condoms. Although the providers said that their facilities provide family planning services, most reported that the services are not strong, particularly in private facilities where the contraceptive options are limited and regular supplies are lacking.

**Knowledge Contribution:** Fertility and abortion trends as seen in the service data and corroborated by provider interviews point to women using abortion as a method of family planning to delay, space, or limit childbearing in Addis Ababa. Although the service-seeking behavior varies between groups of women, most lack correct knowledge of family planning and use contraceptive methods improperly and/or inconsistently. In order to reduce the burden of repeat abortions, policy-makers in Ethiopia should focus their efforts on reaching single, poor, and young women and facilitate regular supply of contraceptive methods at facilities. In addition, more information and education is needed to ensure that, once provided a method, women will use it consistently and correctly to prevent unwanted pregnancy.

B06: 2

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

*Easmon Otupiri*, 1 *Charity Vivian Mote*, 2 *Roderick Larsen-Reindorf*, 3 *Estina Oforiwaa Akowuah* 4

1Kwame Nkrumah University of Science and Technology-School of Medical Sciences, Ghana; 2Komfo Anokye Teaching Hospital; 3Ghana Health Service; easmono@yahoo.com

**Preamble:**
Each year hundreds of thousands of women become pregnant without wanting to; however, over 123 million people around the world mostly in developing countries do not use contraception. Some women opt for unsafe abortions which could prove fatal or leave serious complications.

In an effort to accelerate progress towards achievement of MDG 5, there must be substantial reduction in induced abortion and increased uptake of modern family planning methods.

While induced abortion is legal in Ghana, many women still obtain unsafe abortions due to lack of knowledge at the population and provider level. It is estimated that abortion is the leading cause of maternal mortality in Ghana, and modern contraceptive use remains low. Hohoe district has a projected population of 171,345 (growth rate of 1.9%). The district hospital reported a total of 326 abortions in 2007 with 64% of them being self-induced. Post-abortion complications were the second cause of admissions to the hospital.

Hypothesis/Intervention/Activity Tested

We aimed to describe the pattern of induced abortion among women in the Hohoe district.

Methodology:

We surveyed 408 women aged 15-49 years irrespective of their marital status. Multi-stage random sampling technique was used to select respondents who agreed to enroll in the study after informed verbal consent. The study covered the period July – October, 2008. Structured questionnaires were administered to respondents in Ewe (native language) or in English. The internal review board of the Hohoe District Health Management Team provided ethical clearance.

Questionnaires were checked for completeness, consistency and internal errors daily. The data were double-entered into Epi Info Version 6 (CDC, Atlanta) after coding. We used Epi Info Version 6 for data analyses.

Results

Most (58.8%) of the respondents were married. The mean respondent’s age was 29.9 years and most had been educated up to Junior High School. Most (64.5%) were peri-urban dwellers while 21.0% were urban and 14.5% were rural. Most (70.4%) of the respondents were self-employed and nearly all respondents were Christian (93.9%).

Eighty-seven (21.3%) of the respondents had ever had an induced abortion; 47.1% were married while 52.9% were unmarried. Nearly a third (32%) of those aged 30-34 years had had an abortion; over 80% of those who reported having an abortion were aged 20-39 years. Age was significantly associated with history of induced abortion (p-value=0.002). Among those who had had an abortion, 59.8% had education up to Junior High School while those without education were the least likely to have had an abortion. Education was not significantly associated with induced abortion (p-value=0.178).

Among those who had ever had an abortion, the majority were peri-urban dwellers (75.9%) and 9.2% were urban dwellers (p-value for residence= 0.145). Employment was strongly associated with history of abortion (p-value=0.016).

Common reasons for an induced abortion were: ‘Don’t want to disrupt education or job’ (35.8%), ‘I am too young to have a baby’ (28.4%) and ‘Can’t afford to cater for a baby’ (14.7%). Reasons such as ‘Want to postpone child bearing’ and ‘Don’t want any more children’ were given by 4.2% and 1.1% respectively. Half (52.9%) of respondents had acquaintances who had had an abortion. Their reasons, according to the women in our sample, were similar to our respondents’: ‘Did not want to disrupt education or job’ (31.1%), ‘Can’t cater for a baby now’ (19.1%) and ‘Partner refused to accept pregnancy’ (18.8%). Other reasons were: ‘To postpone child bearing’ (4.9%), ‘Want no more children’ (1.7%), ‘Last child too young’ (6.6%).

Knowledge contribution

According to the preliminary results of the 2008 Demographic and Health Survey, Ghana has a total fertility rate of 4.0, down from 4.4 (in 2003) but the use of modern contraceptives among married women has reduced slightly from 19% to 17%. The current situation in Ghana has generated some suggestions that increase in abortion is likely to account for the reduction in fertility rate. In Hohoe, abortion appears to be easily obtainable and the fact that wanting to delay, space and end childbirth are reasons given for having an abortion suggests that the unmet need for family planning is still very important. We need to match results from contraceptive and abortion studies to develop strategies to address the problems. Nationally, with such low contraceptive use and high rates of abortion it is difficult to see how Ghana can achieve MDG 5.

B06: 3

Motivations and obstacles to use of abortion and contraceptive services in Ukraine

Rachel Louise Criswell

 Fulbright Ukraine; rachelcriswell@gmail.com

(1) Background/Significance

The total abortion rate in Ukraine remains higher than in most Western European countries—618 abortions per 1000 live births in Ukraine as opposed to 341/1000 in Sweden— and the modern contraceptive prevalence rate relatively low—46.9% in Ukraine as compared to 70% in Western Europe (USAID 2007). These statistics contradict the generally negative attitude towards abortion among Ukrainian society, evidenced by numerous surveys. While a significant amount of research has been done documenting this contradiction between social mores and reproductive health practices, there has been little exploration as to the cause of such a gap between attitudes and practices.

(2) Question/Hypothesis

When there is a generally negative attitude towards abortion in Ukraine, why do women continue to use it as a form of fertility regulation at higher rates than women in the rest of Europe? What is standing in the way of preventative methods of fertility control such as modern contraception?

(3) Methodology

Research took the form of over 100 structured one-on-one interviews and focus groups with men, women, and health care providers in six oblasts (regions) of Ukraine. Interviews were held from February to August of 2008 in hospitals (gynecological department), polyclinics (women’s consultations), factories, schools, government administration buildings, and prisons. Respondents were classified based on age, gender, income, residence, children, marital status, and education. The research was done in part as a collaboration with the WHO’s Strategic Assessment of Abortion and Reproductive Health Services in Ukraine.

Analysis of the interview and focus group transcripts was performed in order to draw out the main reasons that women had chosen to have abortions and the main reasons that they unintentionally conceived. In addition, basic tallies of answers to each question were performed in order to highlight basic quantitative data. (The sample size for this research was far too small for any significant quantitative data collection, and quantitative tallying was performed more for organizational purposes than analysis.)
Research was funded by the Fulbright Association of Ukraine, 2007-2008.

(4) Findings

The reasons for the abortion-contraception contradiction are rooted in the health care system and in the economic status of the country, both of which are recovering from the Soviet era. Due to a highly medicalized Soviet health care system that focused on a curative approach to treating illness, preventative care measures, such as contraception, are not well received. Abortion was not stigmatized, and common during the Soviet Union, making it easier for women to have regular abortions than use difficult-to-procure contraceptives. A legacy of distrust of state-run institutions leads to a lack of trust in the contemporary medical system, and many women will only visit health facilities if they need a specific service, such as an abortion, leaving no opportunity for family planning counseling. Even after multiple abortions, a majority of these women will still use “village remedies” or no method to control their fertility, simply because of a lack of correct information. For those who do seek family planning guidance, many medical experts still espouse the cleansing nature of abortion and the dangers of hormonal contraceptive pills and IUDs. This system has very much remained in place in Ukraine, and shifting to a preventative, contraception-based reproductive health care system has been difficult.

This historical curative system is reinforced by economic factors: abortion services in Ukraine are officially free, whereas contraceptives must be paid for by the patient. In a country suffering from economic collapse, many Ukrainians are more willing to pay the associated unofficial costs for occasional abortions when needed rather than continually pay for contraception in anticipation of an unintended pregnancy.

(5) Knowledge Contributed

History and economics play a major role in Ukrainians’ reproductive choices. This becomes a problem as the country faces a demographic decline and the government gets involved in issues of reproductive health with a pro-natal, anti-abortion campaign. This campaign does not consider the question of contraception as a way to plan intended pregnancies in an economically unstable country or the issue of a woman’s right to make her own reproductive health decisions. This research shows the necessity of examining the question of reproduction, family planning, contraception, and abortion in a historical light in order to make informed decisions about how to shift the health care system and social mores to best serve the health of women.

B06: 4

Contraception and Abortion in Zanzibar, Tanzania
Alison Holt Norris, Michelle J Hindin
Johns Hopkins Bloomberg School of Public Health, United States of America; anorris@aya.yale.edu

Background/Significance

Unintended pregnancies can lead to a range of negative consequences: stress on families, loss of educational and economic opportunities, and deaths from unsafe abortion or complications in delivery. In Zanzibar, a semi-autonomous region of Tanzania, abortion is illegal except to save the life of the woman. There are no published studies about abortion in Zanzibar, and only one published piece identifying reasons for the region’s very low contraceptive use prevalence (only 9% of all women in Zanzibar were currently using a modern method of contraception in 2004 (Demographic and Health Survey (DHS) data, 2004)). In order to reduce the number of unintended pregnancies and reduce the morbidity and mortality from unsafe abortions that result from those pregnancies, we must better understand how men and women think about the risks of using contraception, and the risks of abortion, versus the risks of carrying a pregnancy to term. If we can better understand the barriers to contraceptive use and the circumstances around unsafe abortion, we can work with policy makers and reproductive health care providers to develop programs in Zanzibar to improve women’s health and give women and men the opportunity to plan their family size.

Hypothesis

We hypothesize that a variety of barriers prevent sexually active Zanzibari women and men from using contraception, leading to unintended pregnancy. We further hypothesize that the illegal and stigmatized nature of induced abortion in Zanzibar causes women to have clandestine and unsafe abortions resulting in injury and death.

Methodology

The overall study employs a three part multi-disciplinary methodology: 1) a community-based qualitative exploration of contraception and abortion; 2) a hospital-based evaluation of post-abortion complications; and 3) collaborative policy and program development. In the initial qualitative work, we will use semi-structured group discussions and in-depth interviews to evaluate community members’ views of contraception and abortion. We will illuminate social norms, and look also at variation among individuals’ views of contraception and abortion. By asking people about their own reproductive histories, we will learn about their experiences with contraception and abortion, as well as how they have been constrained or empowered to choose contraception or abortion. These qualitative data will be complemented by analysis of Tanzanian DHS data.

We will analyze the semi-structured group discussions and in-depth interviews using the constant comparative method. At the conclusion of each group discussion, the research team will jointly review the main themes of the discussion, and will later review the transcripts to identify important themes and language. Interviews will likewise be transcribed and reviewed. We anticipate that four group discussions and 15 in-depth interviews will achieve saturation for major themes.

These community-based data will inform development of the second component, an evaluation of hospital-based post-abortion complications. For the post-abortion complication component, we will conduct in-depth interviews of health care providers and patients receiving post-abortion care, and administer a questionnaire to patients receiving post-abortion care. In the final component of the study, we will develop policies and programs in collaboration with the Zanzibari Ministry of Health, other policy makers, and service providers.

Findings

Data collection will commence with the qualitative semi-structured group interviews and in-depth interviews in August 2009. By November 2009 we will be prepared to present preliminary findings about the complicated ways in which women’s and men’s views on contraception influence their use of these methods, and how low rates of contraceptive use effects the men and women who experience unintended pregnancies. Specifically, we will address:

1. How women and men in Zanzibar, Tanzania view the consequences and the risks of contraception, abortion, and pregnancy;
2. How these women and men have experienced contraception, abortion, or pregnancy throughout their reproductive lives; and
3. How they have been constrained or empowered to choose from among those three reproductive possibilities.
We will determine how people conceptualize the risk of using contraception versus the risks of abortion (or the risks of carrying a pregnancy to term). Especially important is the role of male partners in decision-making around contraception and abortion, and the way in which the relationship and the life circumstances of both partners affects reproductive decisions.

Knowledge Contribution

We have a goal of increasing access to contraception and reducing morbidity and mortality related to unsafe abortion in Zanzibar, Tanzania. Research about contraceptive use and abortion in Tanzania as a whole is limited, and there is almost no data specific to Zanzibar. This study will provide important information where none currently exists.

With a nuanced understanding of the barriers to contraceptive use, and insights into the stories of women who experience post-abortion morbidity, we will have compelling data to develop programs to reduce the number of unintended pregnancies in Zanzibar, Tanzania. These lessons will be useful for practitioners across Africa who struggle to provide appropriate care for their patients before, during, and after pregnancy.

C06: Franchising FP Services

Time: Tuesday, 17 November 2009: 11:30am - 1:00pm

C06: 1

Private Sector Franchising for Long Term Methods in Kenya

Veronica Musembi, Risha Hess
Population Services International; rhess@psi.org

1. Background/Significance

Long-term methods are underused throughout Africa including Kenya, where use is only 4% (KDHS 2003). Public sector accounts for only 29% of IUD delivery and 61.5% of implants, which means the remainder are inserted through private or non-profit clinics (KDHS 2003). Given this scenario, PSI decided that to satisfy the unmet need; one crucial strategy would be franchising the existing private sector providers.

2. Intervention

Starting in December 2008, PSI mapped private and public sector clinics in seven regions in Kenya. Then, based on selection criteria, PSI selected 113 to participate in the project. These clinics signed an MOU with PSI to become “Tunza clinics” that would provide long-term methods (IUDs and implants) and host “Tunza Days” where PSI nurses and clinical officers support and supervise free insertions. In March 2009, the first round of Tunza providers were trained in long-term methods, in partnership with the Kenya MOH.

Simultaneously, PSI met with women’s groups, or “Merry-Go-Rounds,” to provide information on long-term methods (as well as short-term methods such as the oral contraceptive pill, injectables and condoms) and information about Tunza clinics and Tunza Days. From December 2008 to April 2009, PSI reached 23,163 women of reproductive age through these efforts. Additional women were met by community mobilizers.

3. Methodology

Every woman who received an IUD or implant insertion or removal was logged into a daily activity form using information from her health care visit card. This included information on age, number of living children, age of children, previous family planning method used in the past three months, reason for using and marital status. The data was entered into a database.

5. Findings

IUD Insertions at Tunza Clinics and Tunza Days:

Region Dec 08 Jan 09 Feb 09 Mar 09 Apr 09 Total
Central 86 60 106 217 278 747
Coast 66 31 108 158 156 519
Eastern 66 77 107 123 502 875
Nairobi 53 66 98 102 196 515
Nyanza 60 37 83 205 305 690
Rift Valley 38 43 88 165 124 458
Western 66 17 96 171 257 607
Total 435 331 686 1,141 1,818 4,411

6. Lessons Learned

In comparing this method of private franchising to other methods, there are unique successes and challenges.

Successes include building the groundwork for long-term sustainability as now women have received this method from a well trained and supervised provider, she is familiar with the clinic and can go to this provider for follow-up. Similarly, the provider is trained, and as long as demand remains high enough, providers should be able to properly insert long-term methods for the foreseeable future. Additionally, the strategy of having event days at Tunza clinics was successful in gaining support from private providers to join the network as they saw immediate benefits to membership. Demand creation was crucial to this success and the ability to get women interested in IUDs broke many myths the providers had about these methods not being desired by women in their regions.

Private franchising can be a major part of the strategy in Kenya only because the private sector is fairly extensive and has reach into peri-urban and peri-rural areas. However private sector franchising is a challenge. Some of these challenges include getting providers to feel like partners. NGOs in the past have often initiated franchises that include only branding, training and supplies. The providers have often not been asked to do much other than record keeping. Therefore, when they are expected to provide supplies or even do insertions on Tunza Days, they are surprised. Creating demand and showing them the benefits through Tunza Days has been helpful, but this remains a challenge. Ensuring adequate supplies is also a challenge. PSI provides Tunza clinics with the contraceptives and insertion/removal kits, but has found that even disposable items such as cotton or bleach have been scarce and the provider is not always willing to buy all those items themselves. PSI has bundled the methods to include all necessary disposable items, as well as providing all things necessary on Tunza Days, including exam couches, and infection prevention consumables.
Additionally, the price of the IUD is a barrier to lower income consumers, but the insertion procedure does involve expense and time to the provider, for which they expect compensation. Ensuring a match between these dynamics is a struggle. Finally, obtaining individual client information is another difficulty. In July, PSI will launch an SMS-based data collection system, which will allow providers to enter crucial client insertion and removal information through their phones for which they will receive airtime credit. PSI hopes that this will encourage submission of accurate client data.

C06: 2

**Franchising of Private Providers in Pakistan**

Sohail Agha, Dana Tilson

Greenstar Pakistan; rhess@psi.org

1. Background/Significance

Greenstar Social Marketing Pakistan (Greenstar) is a Pakistani non-governmental organization (NGO) founded by Population Services International (PSI) in 1991. Greenstar’s mission is to improve the lives and health of low-income Pakistanis by increasing the supply, service provision, and demand for family planning (FP) and maternal and child health (MCH) products and services. Greenstar’s main activities are threefold: distributing contraceptives and other health products through private sector pharmacies, health care providers and retails shops; training and developing its extensive private sector health care provider franchise; and generating demand for health promoting products and services through mass media and interpersonal communications initiatives. To assist the Government of Pakistan in achieving its goal of replacement level fertility by 2020, Greenstar has scaled up activities in the area of FP over the last five years. Greenstar is currently supplying about 30% of all FP contraceptives used in Pakistan.

2. Intervention or Activity Tested

The Greenstar and GoodLife Franchise

To assist the Government of Pakistan in expanding contraceptive availability and choice, Greenstar launched a franchise network of trained family planning providers in 1995. This network complemented Greenstar’s condom social marketing program, begun by PSI in 1985. Greenstar trains private providers in FP topics, and then brands the providers under the Greenstar (Sabz Sartr) name.

In 2006, Greenstar launched a new franchise called GoodLife. Understanding the local culture and the subsequent challenges of stand-alone FP services, GoodLife expanded upon the existing franchise, training providers in MCH topics. In the last three years, Greenstar has trained over 4,000 of the new and existing Greenstar providers on the GoodLife topics, such that the majority of the entire network is now trained in MCH and FP.

Greenstar continues to train new franchise providers and build capacity of existing providers through refresher and advanced FP/reproductive health training courses and quality monitoring visits. A key component of refresher training for providers includes hands-on experiential learning during Clinic Sahoolats, or free clinic days at network clinics. During Clinic Sahoolats, Greenstar staff doctors observe provider counseling and technical skills and share their clinical expertise by providing on-site feedback and technical assistance.

Greenstar’s social franchise network of over 7,500 providers is the largest in the world, located in over 107 out of 135 districts throughout Pakistan in all four provinces, including the Federally Administered Tribal Areas (FATA), and Azad Jammu and Kashmir (AJK).

3. Methodology

Greenstar’s management information system (MIS) monitors program inputs, such as number of providers trained, number of neighborhood meetings conducted and number of participants, as well as outputs, such as number of new FP adopters during Clinic Sahoolats. To complement reporting, managers of all departments, regions, and zones conduct spot supervisory visits to provide on-site job training and feedback to their staff.

4. Data

Through Greenstar, PSI distributed over 100,000 IUDs through the commercial sector and franchised clinics from September 2008 to February 2009. During the same period, Greenstar conducted 9,346 free Clinic Sahoolats where an additional 14,867 women received an IUD.

5. Findings

The Planning Commission of Pakistan estimates that half of all FP services and contraceptives are provided by the private sector. Greenstar serves almost 70% of those who access such services and contraceptives via the private sector. Today, the providers in this health network, who are trained in hormonal contraceptives and IUD insertion and are located primarily in low-income urban areas, contribute greatly to achieving the goals of the National Population Program in Pakistan.

Greenstar is expanding service options and improving access in underserved regions. There is significant potential for establishing new private health providers in rural and underserved areas. Existing providers in these areas are often under-utilized because they lack certain capacities. Greenstar believes that it has the experience and ability to successfully train and incorporate many of these providers into its network.

6. Lessons Learned

Demand generation is key to the success of private sector franchises. To generate demand for the clinic services and its health products, Greenstar has the capacity to undertake large national health promotion campaigns using mass media and community mobilization. Greenstar utilizes national television stations, newspapers and radio stations across the country for airing of mass media behavior change campaigns. Greenstar has a large interpersonal communications force, with more than 400 contracted staff that works in the neighborhoods surrounding network clinics. Greenstar is able to provide information and counseling to nearly two million women and men to encourage them to seek preventative MCH, FP and TB services.

Additionally, subsidized product availability and a sales team are crucial to success. With a dedicated work force of approximately 200 sales staff, Greenstar distributes high quality, subsidized contraceptives to more than 100,000 sales points, which include 80,000 retail outlets and 20,000 pharmacies. Greenstar’s distribution staff provides a full range of contraceptives, as well as infant nutrition products.

C06: 3

**Expanding access to family planning products and services: the use of a second tier franchised network in Myanmar**

Jayne Rowan1, Nyo Nyo Minn1, Dan Rosen2

1PSI/Myanmar; 2PSI; jrowan@psimyanmar.org

Background
PSI/Myanmar provides reproductive health products and services to low income communities through the Sun Quality Health (SQH) franchise network of private doctors. SQH members are licensed general practitioners (GPs) with pre-existing clinics serving low-income populations, who work full-time in their clinics and who demonstrate a positive attitude towards quality and equity in health care. The Sun Doctors receive training in reproductive health and contraceptive commodities at highly subsidised prices in return for providing agreed quality standards to the client. In 2008 six subsidized birth spacing products were made available to low-income communities through 881 SQH network clinics. A total of 959,376 reproductive health consultations were made and 214,883 CYPs were generated.

Intervention/Activity

To increase contraceptive access to low income women living within three hours travelling time of a Sun Quality Health clinic, PSI/Myanmar began a pilot of a second tier of franchised health workers known as Sun Primary Health (SPH).

Methodology

SPH workers are village based, serving communities within three hours of a SQH clinic. SPH providers are trained on a range of interventions in addition to family planning including malaria diagnosis and treatment, tuberculosis screening and referral, diarrhoea management and pneumonia diagnosis and treatment. For family planning SPH providers are trained in counselling methods and given knowledge on the full range of contraceptive methods available. They sell condoms and pills at set prices and refer women to SQH clinics for further counselling on injections and IUDs. SPH workers are non-salaried but receive a small margin on the products they sell and get a referral fee for each client received into an SQH clinic for long term method reproductive health counselling.

SPH providers are monitored on a bi-monthly basis by supervisors who evaluate the quality of care given and to ensure compliance against PSI/Myanmar service delivery protocols.

Data

For the period July to November 2008 a total of 88 SPH workers were trained in 4 townships. For the period August 2008-March 2009 2,461 condoms and 7,172 cycles of pills were sold and 430 women were referred to an SQH clinic for reproductive health counselling, of which 427 received an IUD.

Findings

Initial evidence suggests that using a second tier of franchised workers offers potential to deliver quality products and services, including reproductive health to underserved communities.

Lessons Learned

The main strength of using a second tier franchise is the linkage to a Sun Quality Health clinic so that SPH workers can refer women for long term method counselling thus expanding women’s choice.

CO6: 4

Franchising to Increase Access and Use of LTM

Rehana Ahmed, Cynthia Eldridge

Marie Stopes International; rihess@psi.org

1. Background/Significance

- MSI is committed to reaching 20 million CYP by 2010.
- BlueStar franchising is critical to achieving MSI goals of increased access for low income clients to quality sexual and reproductive health services.
- BlueStar franchising is one of the core delivery channels for sexual and reproductive health services within MSI
- BlueStar Ghana started in 2007 with the plan of recruiting 100 providers and providing over 3,000 LTFP and 10,000 CAC services.

2. Research: State main question/hypothesis

Program: State intervention/activity tested

- Working with private chemical sellers, pharmacists, and clinics, BlueStar Ghana is using a partial franchise model to increase access and improve the quality of FP and CAC services

3. Methodology (including location, setting, period, analysis approach)

The MSI BlueStar Social Franchise Model applied in Ghana:

- DHS data revealed that Ghana offered a good opportunity to start BlueStar franchising
- MSIG started by conducting a mapping and baseline study to learn about the location and services provided by private providers. Based on this information, MSIG objectively recruited chemical sellers, pharmacists and clinics.
- After signing a contract and paying a franchisee fee, the franchisees are trained according to GHS and MSI standards in the franchised services including IUD, Implants and CAC. The trainings were often outsourced. Refresher training on MVA has been conducted more frequently.
- Once competency in service delivery was demonstrated, the franchisee’s clinics were branded with a fresh coat of paint, clinic signs and directional signs.
- BlueStar ensured that franchisees have access to low cost, high quality family planning commodities such as Mediprist.
- Regular support supervision ensures that the franchisees provider high quality family planning services. BlueStar has evaluated both administrative and clinical quality through StarScan and QTA. Although rare, clinical complications are handled by MSIG’s Medical Advisory Team.
- Demand creation activities, such as community days, are on going. Community Health Workers have not been used to date.

4. Data (if relevant)

- BlueStar MSIG has 100 franchisees [42 clinics, 26 pharmacies and 32 chemical shops] has offered 2,500 CAC services and 18,320 CYP to date.
- BlueStar Ghana delivers over 30% of the CYPs for the MSIG programme
- Will present up-to-date services statistics, CYP, and other trend analysis of BlueStar Ghana based on recent baseline evaluation, case study documentation, clinical evaluations and exit interviews
5. Findings
- NA

6. Research: State knowledge contribution
Program: State lessons learned
- Mapping and baseline survey were critical to starting a social franchise programme in the right direction
- Selection of provider cadre impacts overall productivity of the programme
- Access to and regular flow of low cost, high quality commodities is an incentive for franchisees
- Franchises value the training programmes, continuing education credits and on-the-job follow up
- Demand creation activities must start with the launch of the programme and are critical to realizing the increase in clients
- Franchise programmes need to work synergistically with MSiG clinics and outreach to be optimally successful.
- Multiple streams of funding are required to maintain the direction and momentum of the programme.

D06: FP and Maternal Child Health Outcomes

D06: 1

The Contribution of Family Planning to Reducing Maternal Mortality

John A. Ross¹, Ann Blanc²
¹Futures Group International, United States of America; ²Engender Health, United States of America; JRoss@FuturesGroup.com

THE CONTRIBUTION OF FAMILY PLANNING TO REDUCING MATERNAL MORTALITY

John Ross and Ann Blanc

Background/Significance
The maternal health field has identified four core strategies to reduce maternal mortality: family planning with related RH services, skilled care during pregnancy and childbirth, emergency obstetric care, and immediate postnatal care. While all four strategies contribute to reducing the number of maternal deaths, the latter three do so by reducing risks among women who are (or were recently) pregnant. In contrast, family planning reduces the number of deaths in two ways: first, by reducing the number of women who become pregnant and, second, by reducing the risk associated with each birth through shifting the composition of births away from those among older mothers and at higher parity.

If accelerated progress on Millennium Development Goal #5 is to be achieved, policy makers must pursue the most effective strategies for improving maternal health. This paper demonstrates that increasing the use of family planning – which can be achieved by fulfilling women’s expressed desire to avoid or delay pregnancy – will have substantial effects on reaching that goal.

Research Questions
This paper aims to answer two primary questions:
- What has been the contribution of the use of family planning to reducing the number of maternal deaths over the past 15 years and what is its potential contribution in the future if contraceptive use continues to rise?
- How has the maternal mortality ratio (MMR) – which measures the average risk of maternal death per 100,000 births – changed due to the joint effects of the three core strategies that reduce risk among pregnant women and to the selectivity in contraceptive use by age and parity?

Methodology
The methods include cross-tabulations and scattergrams, regression equations, and results from simulation trials with the SPECTRUM software of the Futures Group International. A decomposition exercise is also employed.

Data
Data come from the series of Demographic and Health Surveys, and especially from 42 countries that have had multiple surveys. These data are used to show how key indicators have moved together, e.g. unmet need, contraceptive use, and the age or parity distribution of births. Additional information comes from the 2008 UN Population Division estimates and projections for numbers of births and other variables. International maternal mortality ratios (MMR) values come from the WHO/UNICEF/UNFPA 2005 series. Finally, age-specific and parity-specific values of MMRs are drawn from special data sources in Bangladesh, Honduras, Guatemala, Burkina Faso, Sri Lanka, and the historical United States. (A chart is appended to illustrate the dependence of the overall MMR upon the distribution of births by age.)

Findings
1. Total maternal deaths from 1990 to 2005 are estimated for each five-year period, and compared to the higher numbers that would have occurred with (a) no deaths directly averted due to fewer births, and (b) no deaths indirectly averted through shifts in the composition of risky births. Results show that more than a million maternal deaths were averted during this period. Projections that assume a one-point annual rise in the contraceptive prevalence rate are used to estimate deaths averted to the year 2025.

2. A two-step procedure shows first the reduction in high-risk births as contraceptive use increases. The second step uses the decline in high-risk births to estimate the corresponding decline in the MMR. The two steps together provide the relationship between the falling MMR and rising contraceptive use.

3. The best estimate of the international decline in the developing world’s average MMR over a fifteen year period (1990-2005) is a 6% fall (480 to 450). The decline is greater however in selected countries and this is examined to show the size of the change in relation to the rise in contraceptive use. The MMR change is due to the selective effects of contraceptive use together with improvements in maternal health services.

4. A decomposition of changes in total deaths provides an estimate of deaths averted due to fewer high parity and older age births, with the residual change attributed to changes in parity and age-specific risks, all separate from the effects of increased numbers of births.
Contribution to Knowledge

Improvements in maternal health services – skilled care during pregnancy and childbirth, emergency obstetric care, and postnatal care - have saved the lives of mothers by lowering the risk of dying while pregnant or giving birth. In addition, however, the provision of family planning services and the resulting reduction in unmet need for contraception have averted many unintended pregnancies, unsafe abortions, and maternal deaths. The use of family planning has had both direct and indirect effects on the number of maternal deaths. The four core strategies can interact favorably to save lives and simultaneously help women to avoid unwanted pregnancies and achieve their reproductive desires.

Age-specific MMR values in relation to the MMR at ages 20–24

CHART FOLLOWS

D06: 2


Aja Akiode Olusola, E.O. Ojoefiti
Obafemi Awolowo University, Ile-Ife, Nigeria; solaajao2000@yahoo.com

ABSTRACT

Background: Fertility pattern and reproductive behaviours affect infant death in Nigeria. Fertility rates are high with average total fertility rates of 5.6 and 5.2 and region variation ranging from 7.4 in North-west and 3.8 in the south west and 6.5 in women above 35years) or who have too many births (five or more) or too closely spaced (less than 24month apart) are associated with increase infant and childhood mortality. Household food insecurity and poor care practices also placed the children at risk of morbidity and mortality.

Main questions: The objectives of this study are to assess the nutritional status and the care practices of under-five children and identify the influence of family size and other factors on the nutritional status of under-five children in Ile-Ife, Nigeria.

Methodology: The study employed a descriptive cross-sectional design. A semi-structured questionnaire was used to collect data from 423 mothers of under-five and their children in the households using the multistage sampling technique. The instrument measured socio-demographic variables, household characteristics, child care and feeding practices and household food security (based on adaptation of USDA Household Food Security Questionnaire Module). Anthropometric technique was used to assess the nutritional status of the children. Data were analysed using SPSS and using appropriate descriptive and inferential statistics. Statistical significance was placed at p<0.05.

Findings: The mean age of mothers was 31±6.7 years while that of under-five children was 25±14.9 months. The prevalence of stunting, wasting, and underweight among the under-five children were 39.3%, 6.3%, and 14.1% respectively. Nearly all (99.5%) of the children were breastfed. Of these, 332 (80.6%) children were exclusively breastfed for the first 6 months of life, while 80 (19.4%) were breastfed exclusively for shorter periods. The children’s feeding pattern based on mothers’ 72 hours dietary recall leaned towards energy giving food (corn pap, rice, yam flour etc) (45%); body building food (bean, fish, egg etc) were also offered regularly (37%) while protective food (orange, green veg., okro etc) were offered sparingly (8.24%). Fifty-three percent of the under-five were given cow milk or infant formula as a complementary diet. A majority (71.4%) of the children received all the appropriate vaccinations for their age. There was an inverse relationship between family size and the nutritional status of under-five children. Women who had more than two under-five children were significantly more likely to have underweight children (χ² = 4.208, p<0.05). Sixty-five percent of the households were identified to be food insecure while only 35% were food secure. There were significant increases in prevalence of malnutrition in households that were food insecure. Mothers who ate less than desired because of insufficient finances were more likely to have stunted children (χ² = 8.362, p<0.05). Also, children who skipped or reduced meals because of insufficient finance were more likely to be wasted (χ²= 16.970, p<0.05) and /or underweight (χ²= 20.303, p<0.05). Children who were breastfeed for less than six month (χ²= 4.476, p<0.05) and who were fed with cow milk and donut separately (χ²= 12.199, p<0.05) were more likely to be stunted.

There was a significant inverse relationship between the children vaccination status and the prevalence of malnutrition.

Conclusion: The prevalence of food insecurity among households in Ile-Ife was high. Households with large family size, food insecurity and have poor child care practices were more likely to have malnourished children.

Knowledge contribution: The result of this work could inform programme and policy development to advocate for decreasing family size and improving child survival in Nigeria.

D06: 3

The Effects of birth spacing on infant and child mortality and on pregnancy outcomes in Abnoub District, Rural Assiut, Upper Egypt

Etemad El-Shereif, MH Qayed, Ali Zarzour, Kawthar Fadel
Assiut University, Egypt; etemadelsheereef@yahoo.com

1. Background/Significance: Egypt's Strategy for Population recognized that the present demographic trends are important factors aggravating the health and socio-economic situation, placing additional burdens on infrastructures and influencing the welfare of the population. But this was not the only factor influencing the situation. That is why most of strategies are concentrating on the areas of health affecting the vulnerable groups: women, children and poor sectors of the community. Every year nearly 11 million children die before their fifth birthday; 99 percent of these deaths occur in developing countries (UNICEF, 2003). The relationship between short birth intervals and high infant and child mortality has been established in a wide range of population. However, few studies of the effects of birth spacing have adequately adjusted for potentially confounding factors such as breast feeding and socioeconomic factors.

2. Research: State main question/hypothesis: To what extent does the length of the preceding birth interval affect the risks of infant and child mortality, pregnancy outcomes and maternal morbidity.

3. Methodology (including location, setting, period, analysis approach): We conducted a cross-sectional survey in seven villages affiliated to Abnoub District, Assiut Governorate, Upper Egypt, 2008. Eligible women were women between the ages of 15-49 and have at least one child less than 5 years of age. We used a random cluster sampling technique to select the study participants. From the 7 study villages our target was to randomly select 30 clusters (one cluster from each 5,000 population), and 30 eligible women in each cluster making a target of 900 women. We successfully interviewed 942 women (15-49Yrs) who had children <5 years.

4. Data (if relevant): The mortality estimates were calculated from information that was collected in the birth history section of the mothers’ questionnaire. We took a retrospective birth history in which the respondent was asked to list each of her births, starting with the first birth. Data were obtained in the birth
5. Findings: The average number of living children per woman was 3.5±1.9. It increased gradually with increasing age to be 6.6±2.02 among those aged 45 years and older. Out of 942 currently married and sexually active women 429 (45.5%) were using a family planning method at the moment of interview. Among the modern contraceptive methods the IUDs were the most popularly used method, followed by pills, contraceptive implants, contraceptive injections and least were condoms. Birth intervals of less than 6 months were associated with increased risk of pre-term births, small for gestational age and low birth weight. 391 (41.5%) of women did not have lethal outcome of pregnancy. 348 (36.9%) of them experienced abortion. Of 348 women who reported that they had abortions before, 216 (62.1%) experienced one abortion, 124 (14.6%) had two to five abortions and eight women aborted five times or more. Of 72 women who reported that they had still births, 57 (79.2%) had one stillbirth, 11 (15.3%) had two still births and only 4 (5.6%) had three still births. No more than three stillbirths per women reported in our survey. 19.9% of women reported that they had one or more deaths under five. Of all counted pregnancies(4,115) in the obstetrical history of the interviewed women, about 89.35 resulted in live births, 8.5% ended in abortion and 2.2 ended in still birth.

6. Research: State knowledge contribution: We recommended that reproductive health should be seen in a broader perspective than only from a health care provider point of view. There are three major fields of actions for the improvement of reproductive health as: promotion of the education of girls and women, empowerment of the social position of women, and community health education. Also, birth spacing is an important, feasible and practical intervention to address these conditions and should be included in developing country health programs.

**D06: 4**

**Towards Healthy Timing and Spacing of Pregnancies: Postpartum Family Planning- Behavior of Women in rural Jimma, South West Ethiopia**

_Yohannes Wado_

Jimma University, Ethiopia; yohannes.dibaba@ju.edu.et

**Background/Significance**

In rural Ethiopia where use of modern contraception is very low and where more than one third of women have an unmet need for contraception, short birth intervals and unintended pregnancies are among the major contributing factors for the high maternal mortality. Unmet need for family planning is remarkably concentrated among women in their first year postpartum which requires attention from family planning and reproductive health programs. The objective of this study was to examine the family planning practice and reasons for non use among women during the extended (12 months) postpartum period in rural Jimma, southwest Ethiopia.

**Research: State main question/hypothesis**

What is the status and predicting factors of postpartum family planning use in rural Ethiopia, to enable women adequately space pregnancies and reduce unwanted pregnancies?

**Data and Methodology**

The study was conducted in Mana district, Jimma Zone, southwestern Ethiopia. A community based cross-sectional survey was conducted among women who have given birth in the three years before the survey date. Participants were drawn from six rural (kebeles) villages using a simple random sampling procedure. Data were analyzed using SPSS software and frequency distribution, cross-tabulation and logistic regression analyses were done.

**Findings**

A total of 584 women, with a mean age of 28 years, participated in the study. The average number of children ever born was 3.89. About 61% of women reported that their last birth was wanted, 28% said it was mistimed while the remaining 11% reported the last child was not wanted. Analysis of birth intervals for non first births showed that 27% of births occurred within less than 24 months and 33% occurred between 24 and 35 months. Based on the recommendations of WHO technical consultation group who advised an interval of at least 24 months before attempting the next pregnancy (in order to reduce the risk of adverse maternal, perinatal and infant outcomes), the majority of births to women in this study are not adequately spaced to protect maternal and newborn health. Only 35% of births occurred between 36 and 59 months after a previous birth.

With regards to return to fertility and pregnancy risk during the postpartum period, about 65% of women reported to have returned to sexual activity during the first three months after birth, and menses returned for 34% during the same period. Similarly, exclusive breast feeding dropped to 46% by three months after birth. Overall, 27.4% of women in the study reported use of a modern family planning method in their first year postpartum. Current use of family planning among women in their first year postpartum (1-12 months) is 26.7%. The most commonly used methods reported are Injectables (72.8%) and pills (23.2%). The mix of methods provided is limited mainly because family planning services in rural Ethiopia is currently provided by community based health extension workers who may not have the necessary skill to provide method mix as well as information to help women choose methods appropriate to postpartum women.

Among women who are not using modern family planning methods, the major reasons mentioned for not using are; menses not returned (37.9%), desire for additional child (18.2%), fear of side effects (10%), husband opposition (8%) and religious opposition (7.6%). But, a significant proportion of women who are not using Family Planning (43%) intend to use in the future. On the logistic regression analysis; younger age, mother’s education, desire for no more children, prenatal care visits and postpartum health facility visit were the factors that independently predicted the use of family planning during the postpartum period.

**Research: State knowledge contribution**

The study showed that a low proportion of women who have recently given birth are using family planning in rural Ethiopia, despite the fact that a significant proportion of their previous births were mistimed and unwanted. Thus, ensuring that postpartum women have access to a mix of family planning methods, counseling on return to fertility and birth spacing and improving prenatal care and postpartum health care contacts are important strategies to improve the use of family planning and reproductive health services during the postpartum period.

**D06: 5**

**Systematic Review of Childbearing Patterns and Maternal Mortality**

_Wei Huang, Carine Ronsmans_

London School of Hygiene and Tropical Medicine, United Kingdom; wei.huang@lshtm.ac.uk

**Background/Significance**


Family planning is one of the four pillars of safe motherhood and often included in initiatives aimed at achieving the Millennium Development Goals. It is obvious that prevention of pregnancy removes the risk of maternal death completely. However, this only applies to a restricted population of women who do not want more children. Family planning can also influence maternal mortality through a reduction in the number of high risk pregnancies. Pregnancies to very young, very old, primiparous or multiparous women are thought to increase the risk of maternal death. However, the impact of a pregnancy risk distribution shift on reductions in maternal mortality is not known. As more developing countries experience demographic transitions, it is important that we understand the impact of changing childbearing patterns on maternal mortality.

Main questions

Our study aims to investigate the strength of the associations between maternal age, parity and maternal mortality at the population level through a systematic review and appropriate meta-analyses. In particular, we are questioning the generally accepted assertion that pregnancies in young, old and multiparous women are particularly at high risk.

Methodology

We searched Pubmed, Embase and POPLINE using a comprehensive search strategy. References of included studies were hand searched and data were extracted using standardised forms.

We used a fixed effect model to summarise odds ratios when there was low inconsistency (I²< 30%) or 30%≤ I²< 50% and low heterogeneity (p<0.1). Otherwise, a random effects model was used. An a priori subgroup analyses by area-specific total fertility rate (TFR) was planned. The TFRs were grouped as low (TFR< 2.5), medium (2.5 ≤ TFR< 5) and high fertility (TFR≥ 5).

Findings

Sixty-three studies met the inclusion criteria for the maternal age review and thirty-eight studies for the parity review. Only eight studies reported any adjusted estimates, of which five adjusted for maternal age and parity together.

The meta-analyses provided compelling evidence that very young adolescents (<15 years old) had an 3.94 (95%CI: 3.18-4.88) fold increased odds of maternal death compared to women aged 20-24 years, but adolescents aged 15-19 years were not at increased odds of death compared to women aged 20-24 years (pooled crude odds ratio (PCOR)=1.02, CI: 0.93-1.11). Increased odds of maternal deaths from 25 years old onwards were observed and the odds increases with increasing maternal age (<20 years PCOR= 1.18, CI: 1.09-1.27; 25-29 years PCOR=1.22, CI: 1.14-1.30; 30-35 years PCOR=1.84, CI: 1.68-2.02; 40+ years PCOR= 5.80, CI: 4.98-6.78).

Increased odds of maternal deaths for women aged> 15 years and ≥ 30 years were independent of fertility levels. Adolescents aged 15-19 years were at increased odds of maternal death whilst women aged 25-29 years were not in the highest fertility group. After adjustment for any confounders, increased odd of maternal deaths persisted for all age groups except for the <20 years (pooled adjusted OR (PAOR)=1.03, CI: 0.88-1.2), 25-29 years (PAOR=0.86, CI: 0.36-2.07) and ≥40 years groups (PAOR=1.18, CI: 0.18-7.6).

The meta-analyses demonstrated that primiparity and multiparity were associated with increased crude odds of maternal death. Primiparous women were at a 1.39 (CI: 1.27-1.52) fold increased odds of death compared to parity one women. The effect was independent of fertility levels and it persisted after adjustment for confounders if a Chinese study that has differential fertility policies was excluded (PAOR=2.50, CI: 1.46-4.28). For multiparity, the threshold at which the increased odds began varied by fertility levels. In low fertility levels, the odds increased from parity two (PAOR=1.44, CI: 1.30-1.61), while in high fertility settings the odds only increased for women of parity four or more (PCOR=1.65, CI: 1.24-2.20).

After adjusting for maternal age and parity together, two studies found the young age effect (<20 years) completely disappeared, while a third found the association weakened. For the older age effect, one study found strengthened associations after adjustment with parity for women aged ≥30 years, while the other found decreased odds for women aged ≥25 years after adjustment.

All three studies that reported age adjusted parity estimates found the association between first pregnancies and maternal death strengthened after adjustment. Two studies found no high parity effect after adjustment for maternal age, whilst a third found decreased odds of maternal death for parity 5+ women after adjustment.

Knowledge contribution

The results from this study suggest that very young adolescents, primiparous and older women may be at higher risk of maternal death. The evidence for an adverse effect of higher parities is weak. Too few studies have adjusted for age and parity together or for the potential confounding effects of socio-economic factors to be able to draw conclusions about the causality of any of the associations.

The results add to the growing concerns of effectiveness of a “high risk” approach to family planning. Without improved access to high quality continuum of care for pregnant women the high risks of individual pregnancies are unlikely to reduce by much.

E06: Interactions: FP and the Environment

Time: Tuesday, 17 November 2009: 11:30am - 1:00pm

E06: 1

Integration with marine conservation enhances the acceptability and use of family planning in the Philippines

Joan Castro
PATH Foundation Philippines, Inc.; Linda.Bruce@ccc.urt.edu

Background/Significance

The Philippines is the 12th most populous country in the world and among the fastest growing in Asia. Over 60% of Filipinos reside in coastal zones where rates of poverty, fertility, and migration exceed national averages and factor largely in an emerging food security crisis linked to over-exploitation of fish. Lack of communications and transportation infrastructure in coastal areas pose challenges to the delivery of health and family planning services, while religious and cultural barriers further impede access to, and use of, modern methods of family planning (FP).

Research/Program/Methodology

The Integrated Population and Coastal Resource Management (IPOPCORM) initiative promotes a holistic approach to food security by supporting integration of reproductive health into coastal resource management (CRM) agendas and programs. IPOPCORM offers planning, technical and financial assistance to local institutions and coastal communities working towards three desired outcomes: (1) improved reproductive health outcomes of coastal residents, (2) enhanced
management of marine and coastal resources at the community level, and (3) increased awareness and support for cross-sectoral approaches to population, health and environment (PHE). To achieve these results, PFPI encourages and supports public-private partnerships between local government units, non-governmental organizations, and private sector groups committed to working together to build the capacity of fisherfolk to plan their families, protect coastal environments, and engage in alternative livelihood activities that reduce fishing effort.

Methodology

IPOPCORM works in selected municipalities with high unmet need for FP and high priority for conservation of marine biodiversity. Main target groups include fisher folk, youth, and small entrepreneurs living in high-growth marine hotspots. With key stakeholders, IPOPCORM developed a framework assessing the links of population, health and environment, identifying threats, root causes and opportunities for intervention. This process identified a mix of interventions contributing to the IPOPCORM goal of improving the quality of life of communities that depend on coastal resources while maintaining productivity of life-sustaining ecosystems. Among these are behavior change communications (BCC) and peer education interventions that encourage youth to become stewards of their sexuality and the environment. Adults were encouraged to plan their families and participate in community-based fisheries management activities to improve food security. Owners of small convenience stores were trained to educate, sell FP commodities, and refer for other methods. Small-scale fishers were targeted for assistance because they comprise the bulk of the coastal population, considerable proportions are living in poverty, and they have unmet needs for FP services.

Data

The project established a Behavioral Monitoring System (BMS) and conducted periodic surveys among target groups to track and monitor changes in community attitudes and behaviors over time including reproductive health and fishing behaviors. Three survey rounds were conducted during 2003-2006 in 14 coastal municipalities where IPOPCORM was implemented. A random sample of over 1400 adults was interviewed in each survey round. The majority of respondents were indigenous residents of barangays (villages) with fishers comprising the largest group.

Findings

Overall, the proportion of adult respondents reporting use of any method of FP increased from 43% in 2003 to 83% in 2006 with modern methods comprising the largest increase. Oral pill was consistently the top reported method used during most recent sexual intercourse in all sites and survey rounds. Withdrawal was the second most commonly used method, but by 2006 its use had declined significantly replaced by condom use. These results can be attributed to the BCC interventions introduced by the project which increased peoples’ awareness of the use-effectiveness of modern FP methods and the risks associated with withdrawal practice, and to the network of Community Based Distribution (CBD) outlets established under the program which expanded access to contraceptives by 10-fold.

Improvements in conservation and fishing practices were also observed across the sites and study rounds. Whereas only 40% of fisher respondents helped guard a fish or mangrove sanctuary in 2003, the proportion had increased to 49% by 2006. There was also a reduction in the numbers of fishers that engaged in illegal fishing activities over the same time period. These changes are attributed to the project’s BCC which increased community awareness of three critical results needed to assure food security from the sea e.g., stop illegal fishing, protect critical habitats and reduce fishing effort.

Knowledge contribution/ State lessons learned

- Coastal resource management provides a comprehensible context for coastal residents to recognize the necessity of limiting family size to achieve food security and improve family welfare
- The provision of FP enhances the sustainability of conservation gains
- Integrated approaches add value to conservation efforts via greater female involvement in environmental management activities and organizations, greater access to men and increased participation of adolescents
- By promoting reproductive health management as an integral component of natural resource management, the IPOPCORM project was able to deflect opposition from religious leaders and conservative groups in the community

Integration with marine conservation improves access to family planning for traditional Muslim and semi-nomadic communities on the Kenyan border with Somalia

Abdiiwahab Elmoge Ahmed1, Ali Mwachia2, Sam Weru1, Judy Oglethorpe2, Cara Honzak2, Terri Lukas3

1WWF-Kenya; 2WWF-USA; Linda.Bruce@ccr.uri.edu

Background/Significance

Since 2003, World Wildlife Fund’s (WWF) population, health and environment (PHE) program has worked in eight countries to increase access to family planning and basic maternal and child health care in areas where people have poor access to health services and population growth has serious impacts on natural resources and biodiversity. One of WWF’s PHE projects was launched in the Kiunga Marine National Reserve (KMNR), on the coast bordering Somalia. Home to about 19,000 people, health needs in and around the reserve were dire. Contraceptive prevalence rates (CPR) were 7% as compared to 39% nationally, and maternal and child mortality, malaria and HIV/AIDS were notably high. Health problems were exacerbated by illiteracy, widely practiced polygamy, and lack of information. Due to security risks, the relatively small size of the population and the challenges of working in this remote area, the Kenyan Ministry of Health (MoH) struggled to provide basic health care for local populations. Few non-governmental organizations ever ventured into the area. WWF had a strategic interest in the population’s reproductive rights and well-being, and the ecological integrity of the area’s resources. The area is a global priority for marine conservation, supporting the richest marine fishery in Kenya and nesting sites for turtles. Increasing population pressure and demand for fish threatened the local population’s long term welfare and the integrity of vital marine ecosystems.

With support from USAID’s Office of Population and Reproductive Health and Johnson and Johnson, in 2003 WWF partnered with the MoH, AMREF and later with Family Health International (FHI) to provide family planning and maternal and child health care throughout the KMNR area. PHE work included capacity-building of MoH and communities, improving access to family planning, providing essential maternal and child health services through community-based distributors and mobile clinics, improving water supplies and sanitation, and conducting outreach with integrated messages about health, family planning and natural resources.

Research/Program/Methodology

From the project’s inception, WWF developed a rigorous monitoring and evaluation system for the KMNR, to comprise part of the evidence base for evolving hypotheses about the value added of integrated PHE for conservation. Simultaneously, WWF developed a strategic review to test existing hypotheses. From
2004 to 2008, WWF reviewed 14 projects carried out by conservation organizations that integrated family planning and health into conservation projects. Two WWF assessments contributed to the findings: 1) a study on the value-added of PHE for conservation that included 7 non-WWF projects and a literature review, and 2) an evaluation of 7 WWF PHE projects (including the KMNR project).

Both assessments aimed to identify existing evidence of the benefits of PHE linkages in the conservation sector. WWF staff conducted semi-structured interviews with field project managers based on conceptual models from PHE literature. Diagrams were constructed articulating their assumptions about PHE linkages. Based on these diagrams, data were solicited and hypotheses explored. An independent consultant also conducted field visits, interviewed stakeholders and led focus groups.

Findings
The review documented the state of knowledge about common patterns of assumptions held by conservation practitioners implementing PHE activities. Strong evidence existed to demonstrate that the approach creates an entry point for conservation and increases use of family planning. The review also identified linkages with less evidence, key enabling conditions for PHE, and pitfalls in practitioners’ logic.

The KMNR project is highlighted because it demonstrates common patterns found among the review’s sample. Use of family planning increased. From 2003 to 2008, the modern contraceptive prevalence rate increased by 10%, which is a positive outcome for such a remote area. By 2008, men, many of whom were initially uncomfortable discussing family planning, began to consult with nurses about family planning. Project-trained health educators used PHE messages that integrated information about trends in fish stocks, livelihoods and desired family sizes to broach the topic of family planning.

The project also achieved successes in conservation. In the KMNR, WWF had been struggling for years to overcome a history of mistrust among communities about the creation of the Reserve and WWF’s perceived close affiliation with law enforcement. Provision of maternal and child health care, including family planning, catalyzed community buy-in to conservation, leading to the establishment of no-take fishing zones for the first time, communities taking ownership of turtle monitoring (with the proportion of nests reported by community members rising from 50 to almost 75%), and to 100% of fishermen exchanging their unsustainable fishing gear for more sustainable nets.

Knowledge Contribution
The results of this review and the Kenya case in particular, suggest that packaging family planning with basic maternal and child health interventions, and delivered in partnership with conservation organizations in their priority landscapes, can achieve synergistic results in settings that had traditionally been challenging to reach. Additional lessons from the Kenya case that underscore global findings will be elaborated in the presentation.

E06: Population, Health, and Environment in Uganda: Bwindi Impenetrable National Park Case Study
Gladys Kalemé-Zikusoka1, Lynne Gaffkin2
1Conservation Through Public Health; 2Evaluation and Research Technologies for Health Inc; Linda.Bruce@ccr.uri.edu

Background
Bwindi Impenetrable National Park (BINP) is home to an estimated half of the world’s critically endangered mountain gorillas. Bwindi is also surrounded by some of the poorest people in Africa with high fertility, high population density (200 to 300 people per square kilometer), and limited access to basic modern health services and education. Additionally, the close genetic relatedness (98.4%) between people and gorillas presents an opportunity for cross-species disease transmission, of which scabies skin disease has already been recorded. Understanding these interrelated challenges, Conservation Through Public Health (CTPH) - a grassroots Ugandan and US registered non-profit - developed a Population, Health and Environment (PHE) program around the park with initial funding from USAID. Through integrated conservation and community public health interventions including family planning (FP), the program aims to prevent and control disease transmission between people, gorillas and livestock, improve health and livelihoods, and cultivate a winning attitude to conservation and public health in local communities.

Research/Program/Methodology
CTPH initially supported three efforts around Bwindi: wildlife (gorilla) health monitoring, human public health (community-based direct observation of treatments short course therapy - CBOTS - for TB control) and information, education and communication (IEC - through community telecenters). In 2007, a complementary community-focused FP component was added and the activities integrated as a PHE program.

FP activities were added in two high human-gorilla conflict parishes, Bujengwe and Mukono parishes in Kanungu District, with a population of approximately 5000 people per parish. Through meetings with community leaders from each village (22) in the two parishes, four community reproductive health workers (CHRWH) and 24 (50% male/female) couple peer educators (CPEs) were selected to support community FP sensitization, one on one counseling, provision of self-administered methods and referral, as appropriate. Community health volunteers were also trained to give health talks on scabies and HIV during TB CBOTS and FP home visits. During Year 1, Depo-Provera provided at referral clinics was the most popular contraceptive method although access to the method was hindered by system challenges including availability of trained clinic providers. In response, in 2008, CTPH initiated community-based Depo-Provera provision through training of a subset of the community volunteers (9 female/ 4 male) with support from Family Health International (FHI).

Community volunteers were trained to collect information on number of project activities, including: village health talks, homes visited, new FP acceptors, commodities and IEC materials distributed, and families that saw gorillas nearby (proxy measure for proximity to the park boundary).

Findings
During this years, the number of confirmed new FP users among volunteer household clients was four times higher than expected based on historic clinic trends (147 and 149 in year 1 and 2, respectively, approximately 6% annually of the women of reproductive age in the two parishes). Importantly to the integrated nature of the project, around 40% of the homes visited bordered the park (measured as family members saw gorillas nearby), considered at higher risk for human/wildlife interaction including disease transmission. Another positive result of project integration was the 11-fold increase in number of community TB suspected referred for testing (480 by PHE volunteers versus 40 from the routine program). In addition to increasing first time users of a modern FP method, the project identified women interested in long-term methods for which they were referred to a partner clinic (e.g. 12 women received implants at the BCH). In the ten months during which Depo Provera has been supported by the project, community based distributors (CBDs) have registered 332 new DMPA users and provided 730 injections, 563 (77%) for continuing users. Overall, the CBDs have provided 78% and 25% of all injections administered in Bujengwe and Mukono parish, respectively. Relatively more injections were recorded for CBDs in Bujengwe, in part, because of the central location, capacity and DMPA service availability at the well-equipped BCH in Mokono parish.

Lessons Learned
• Hygiene and sanitation in the community have improved due to repeated home visits by CPES and CRHWS but this needs to be quantified.
• Burden at health centers is being reduced and client demand is increasingly being met through the CBDS.
• Integration strengthened both the community-focused FP and TB programs and the efficiency of both initiatives.
• Integrated PHE messaging using newly created innovative flip charts increased FP acceptance in the community.
• Targeted home visits through a community volunteer network ensure that communities bordering the park get PHE benefits.

E06: 4

Integrating Population, Health And Environment In Oromia And South Regions Of Ethiopia
Negash Teklu
Consortium for the Integration of Population, Health and Environment (CIPHE); Linda.Bruce@ccr.uci.edu

Background
Ethiopia has experienced rapid environmental degradation over the past 20 years, including loss of forest cover and wetlands. At the same time Ethiopia’s population has grown from 42 million in 1984 to 77 million in 2008. People’s reliance on natural resources as main sources of livelihood combined with a high unmet need for family planning (FP) exacerbate one other and create challenges for achieving development goals. CIPHE is a capacity building network based in Ethiopia receiving funding from EngenderHealth and the Packard Foundation to build the capacity of Ethiopian development practitioners in integrating population, health and environment interventions. CIPHE works to build the capacity of local practitioners working in small communities that face interrelated challenges so they can intervene in multiple sectors. Two organizations in Ethiopia have been implementing integrated projects in different regions within Ethiopia and shed light on the role FP can play in achieving multiple community development goals.

Research/Program/Methodology
The Gurage People’s Self-help Development Organization (GPSDO) started working in the Gurage Zone of Ethiopia 48 years ago and since their establishment has focused on bettering the Gurage people’s communities and lives. In 2007, GPSDO identified environmental degradation as a major challenge observing that rapid population growth, dependence on natural resources for livelihoods, and unmet need for family planning combined to make resource consumption unsustainable. As a result GPSDO developed a youth development RH/FP program integrated with environmental protection activities, funded by the David and Lucille Packard Foundation. GPSDO employs several interventions focusing on environmental protection and rehabilitation, adolescent RH/FP, malaria treatment and prevention, and water and sanitation and works closely with government development agents and health extension workers.

The Ethio Wetlands and Natural Resource Association (EWNRA) project is located in Wichi watershed (catchment) in Oromia, South Western Ethiopia. The objective of the project is to improve the value and function of the watershed/wetland resources to contribute towards food security. Activities address the health, livelihoods, and environment through implementing integrated FP and wetland and watershed management practices with the involvement of the local communities and other stakeholders

Findings
Within one year of project implementation GPSDO had already noted significant results including: 289 stakeholders trained to integrate environment and RH/FP activities, 44,250 community members informed about environmental protection issues, and 18,267 FP clients served. By 2008, FP services reached 74,937 people, and prevalence changed from 8.1% in 2005 to 23.66% in 2008. In addition degraded land was identified and discussions with local government have led to rehabilitation efforts.

The EWNRA project has led to improved farmers’ knowledge on the values of healthy ecosystems, natural resource management, and agro-forestry practices, while at the same time receiving information on HIV/AIDS prevention, FP, and general health through links with government health services. Additional aspects of the project such as micro-credit and fuel saving stoves are also having great impact.

Lessons Learned
Both projects illustrate that an integrated PHE approach that includes FP better addresses the diverse and serious problems of communities with a minimum amount of additional resources. Integration efforts and strengthening collaborations with institutions working on RH/FP, and HIV/AIDS contributed positively to the success of the program. GPSDO has also found that reinforcing the recognizing the importance of community based reproductive health agents at the grass-root level is essential for the sustainability of the program.

Furthermore, an integrated approach enables communities to identify site specific problems and key entry points and helps win commitment and trust of the community. Working with traditional community based organizations helps create sense of ownership and sustainability. Participation of women in decision making and benefit sharing was vital to projects and the harmonization of population-health-environment linkages (facilitate improvement of household income, easy application of reproductive health, improve homestead productivity and efficient resource utilization).

F06: Contraceptive Practice in Uganda

Time: Tuesday, 17 November 2009: 11:30am - 1:00pm

F06: 1

Providers Knowledge, Attitudes, Practice and Competencies for the provision of Post-Abortion Services and Contraception in six districts in Uganda

Janet Adongo
Mariestopes Uganda, Uganda; janet.adong@mariestopes.or.ug

1. Background/Significance
Abortion is illegal in Uganda, and unsafe abortion is responsible for at least 30% of all maternal deaths. Most abortions carried out in Uganda take place in secrecy under unhygienic conditions. Each year, an estimated 297,000 induced abortions are performed in Uganda, and nearly 85,000 women are treated for complications, as a result of unsafe abortion (Susha.ela, S. et. 2005). Abortions occur at a rate of (54 per 1,000) women aged 15-49 and account for one in five maternal deaths in the country. Lack of access to adequate family planning (FP) services is a major contributor to the global problem of unsafe abortion; conversely, unsafe abortion is a prime indicator of the unmet need for safe and effective contraceptive methods. In most health systems, women treated for abortion complications rarely receive any counseling or services to prevent subsequent unwanted pregnancies (FP Perspectives, 2007). According to the
Ministry of Health Post Abortion Care protocol, the provision of family planning counseling and methods is one of the requirements for the complete continuum of Post Abortion Care services. Given the background, in 2007 the International Planned Parenthood Federation (IPPF) funded Marie Stopes Uganda to implement the “Post Abortion Care Services and Education” project for a period of two years with the aim of reaching out to about 1,117,000 vulnerable women in six underserved districts in Uganda. The high fertility rates, high levels of unmet FP need and weak health infrastructure justified the implementation of the project in these districts.

To achieve it’s objectives, PACE project had to work with health providers in both public and private health facilities to provide the much needed post-abortion care services to the target communities. These were to be given knowledge and clinical skills, such as, use of MVA kits, FP counseling and service provision and establishing referral links with the communities. The project would therefore have to rely greatly on the technical capacity, commitment and attitude of the health providers to provide the required services. It was therefore imperative that a study be done in order to assess the providers’ knowledge, attitudes, experiences and baseline competencies for provision of post-abortion care services including FP counseling and method choice to the communities.

2. Hypothesis
The study intended to assess the health providers’ pre-training knowledge and opinions on issues related to unwanted pregnancies and unsafe abortions; to establish the Health Providers knowledge and experience with the case management of Post-abortion complications and family planning services; establish the factors hindering the provision of quality Post-abortion care services including family planning counseling and provision of methods related both to the facility and the community.

3. Methodology: The study was qualitative and used the in-depth interview methodology with individual respondents who were by then participants in training sessions organized by Marie Stopes Uganda in six districts of the project. In order to obtain baseline information, interviews were done prior to the start of the trainings. A focus group discussion was used to draw common knowledge from the health workers and the Village health teams on post abortion care services including family planning counseling and services in the community. Thematic and content analysis was used to analyze the data.

5. Findings:
Key findings were that unwanted pregnancies and unsafe abortions are common in the communities. Abortions are done using traditional methods, self-induction with local herbs and used drugs. Clients who present at the facilities with complications of abortion are aged between 14 and 35 and are still sexually active. It was established that a number of factors limit provision of family planning services to women who have experienced an abortion, increasing the woman’s risk of repeated unwanted pregnancies. These included, lack of understanding of and attention to women’s reproductive health needs on the part of providers, lack of services for specific groups of women (e.g., adolescents, single women), separation of emergency post abortion care services and family planning services, lack of knowledge among providers about appropriate post abortion counseling and contraceptive methods, attitudinal problems like lack of acknowledgment of the existence and negative outcomes of unsafe abortion among the providers and their communities and the inadequate supplies of FP methods in the health facilities. Lack of motivation for Health Workers was also found to be a key factor.

6. Knowledge contribution
The findings in this study will demonstrate the need for a range of contraceptive methods, accurate information, sensitive counseling and referral for ongoing care being made accessible to all women who have experienced abortion. It will also show the need to establish strong functional links between emergency post abortion care services and family planning services, developing protocols for post abortion contraception including ongoing training for service providers in order to improve skills and change attitudes, using research to support improvements in the quality of post abortion care.

F06: 2
Trends in Unmet Need and Demand for Family Planning in Uganda
Shane Khan1, Sarah E.K. Bradley2, Joy Fishe1, Vinod Mishra1
1United Nations Children’s Fund, Panama; 2ICF Macro, United States of America; vinod.mishra@macointernational.com

Background: Uganda is the third fastest growing country in the world. Contraceptive use is low, and the unmet need for family planning is high. In 2006, only 24 percent of currently married women in Uganda were using contraception and 41 percent had an unmet need for family planning.

Hypothesis: The study examines levels, differentials, and trends in unmet need and demand for family planning among various groups of Ugandan women. The study also explores factors associated with unmet need, and estimates potential impact of reducing unmet need on total fertility rate.

Methodology: The study estimates levels of unmet need for spacing and limiting, as well as total demand for family planning at three time points between 1995 and 2006. The differentials by important sociodemographic characteristics are presented for the most recent set of unmet need estimates. Multivariate logistic regression models are used to examine factors independently associated with unmet need, separately for spacing and limiting. Finally, a simulation analysis estimates potential impact of reducing unmet need on total fertility rate.

Data: The study uses data from three consecutive rounds of nationally representative Uganda Demographic and Heath Surveys, conducted in 1995, 2000/01, and 2006. Number of women age 15-49 included in the three survey rounds were 7,070, 7,246, and 8,531, respectively.

Findings: Unmet need is increasing among the all women, currently married women, sexually-active women, and never-married sexually-active women. Unmet need remains steady at low levels among never-married women and formerly married women. Unmet need for spacing is more prevalent than for limiting. Women with an unmet need for spacing and limiting both tend to have more than two living children. Women with an unmet need for spacing are more likely to lack employment, live in the Northern region, and not receive family planning messages in the media while women with an unmet need for limiting, in contrast, tend to be older and live in rural areas. Total unmet need is associated with higher parity (2 or more children) and living in the Northern region. Based on the simulation analysis, modest declines in unmet need and increases in contraceptive prevalence in Uganda can substantially reduce the country’s total fertility rate.

Knowledge Contribution: The study identifies population sub-groups in Uganda with higher levels of unmet need for family planning, and demonstrates the value of reducing unmet need in reducing the fertility level.

F06: 3
Knowledge and Utilization of Family Planning Among Women of Reproductive Age in Northern Uganda
Frederick Kintu Mubiru, Jimmy Odong
Marie Stopes Uganda, Uganda; fred.mubiru@mariestopes.or.ug

1. Background/Significance
With support from the Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative, Marie Stopes Uganda, in partnership with Canadian Physicians for Aid and Relief (CPAR) is implementing a five year project in five of Northern Uganda’s conflicted affected districts of Amuru, Kitgum, Lira, Pader and Gulu. Overall, the objective is to ensure that good quality comprehensive reproductive health services are routinely provided to the populations in conflict affected areas.

2. Research: State main question/hypothesis

A survey was conducted in August of 2007 to provide baseline data for the project area. The survey aimed to collect population data on the Reproductive Health status of women of reproductive age, living within the catchment areas of 2 urban and 4 rural facilities. This assessment of reproductive health knowledge, attitudes and behaviors will be used to define the baseline characteristics of target population, guide local programme planning and behavior change communication material development and to inform local advocacy efforts.

3. Methodology (including location, setting, period, analysis approach)

A multi-stage cluster sample (10x25) in each rural area and 15x25 in each urban catchment area) was drawn from the target population of RAISE supported facilities. A pre-coded questionnaire covering basic socio-demographic characteristics and knowledge, attitudes and behaviors related to safe motherhood, family planning, RTIs including HIV, and gender-based violence was implemented. This questionnaire was adapted from the US Centers for Disease Control (CDC) Reproductive Health Assessment Toolkit for Conflict- Affected Women. The questionnaire was written in English, and translated into local languages. Trained Interviewers from communities of the North implemented the tool. A total of 1565 women were interviewed.

4. Findings

The analyzed survey data will be used at this conference to describe knowledge and use of family planning among the women of reproductive age within the RAISE catchment areas of Northern Uganda. Data suggest that while many women report having heard of some modern methods of family planning (88.8%), few have been given information on how to use methods. Only 6% of the women in this survey reported having been instructed on how to use the methods. Current use of family planning was low, with condoms, pills and injectables being the most commonly reported methods. It was noted that while many sources of methods for current users were health units and hospitals, some women (5.7%) reported that they obtained pills and injectables from Traditional Birth Attendants or traditional healers. Reported current use of long term and permanent methods was very low. Use of implants, IUDs and tubal ligation was only at 7.7%. Data on barriers to use of modern methods of family planning showed that fertility related reasons were highest at 62.6%. Other reasons were opposition to use at 34%, method related reasons at 15.9%, lack of access at 11.7% and lack of knowledge at 11.2%. Socio-demographic data showed that young women were more likely to report fertility related reasons and opposition to use, while older women were more likely to report method related reasons and lack of access as barriers to use of family planning. Lack of access was not a major barrier among the educated.

5. Research: State knowledge contribution

- Women in Northern Uganda have been marginalized over the past three decades. They suffer disproportionately from maternal mortality resulting from complications in pregnancy.
- Knowledge of modern Family planning methods is almost universal in Uganda, however, it utilisation is still very low and needs to be addressed.
- The contraceptive prevalence rate in northern Uganda has increased slightly according to this survey from 11 % (2006, UDHS) to 14.6 % (RAISE PBS, 2007), it is still lower in this region than elsewhere in Uganda. These women have the right to quality health services and access to a broad method mix of family planning.
- Family planning interventions in Uganda should focus on addressing the fertility related barriers to family planning use and opposition to use.
- The low utilization of long term and family planning methods in the region should be addressed.

FO6: 4

**Trends in Modern Contraceptive Prevalence Rate among Currently Married Women in Uganda: 1988-2006**

**Joseph Matovu**

Makerere University School of Public Health, Uganda; jmatovu@musphdc.ac.ug

Background: While family planning services have been promoted in Uganda since 1957, uptake of modern family planning methods remains low. Reasons for this range from limited access to and choice of family planning services, side effects associated with method use, opposition to family planning by either or both partners, and cultural influences in favor of large families.

Objective: To assess trends in modern contraceptive use among currently married women aged 15-49 years in Uganda, from 1988-2006.

Methods: We conducted a review of literature available from Uganda Demographic and Health Surveys (UDHS) conducted in 1988/89, 1995/96, 2000/01 and 2005/06. During the surveys, data were collected on socio-demographic characteristics, knowledge of modern contraception, and current and ever use of any modern contraceptive method (Pills, injectables, implants, female sterilization, and intra-uterine device IUD) among currently married women aged 15-49 years. Only women who were currently married at each survey and were aged 15-49 years were considered for this review. Modern contraceptive prevalence rate was defined as the percentage of currently married women who reported using a modern method of family planning.

Results: Majority of the women surveyed (>70%) were below 35 years of age, had primary or higher education (>60%) and were living in rural areas (>80%). Overall, knowledge of modern contraception increased from 78% in 1988/89, 92% in 1995/96, 98% in 2000/01, and 97% in 2005/06 (P<0.001). Significant method-specific increases in knowledge of modern contraception were noted for injectables (41% in 1988/89 to 93% in 2005/06, P<0.001), pills (from 6% in 1988/89 to 93% in 2005/06, P<0.001) and Norplant (from 6% in 1995/96 to 64% in 2005/06, P<0.001). While knowledge of IUD as a modern contraceptive method increased from 20% in 1988/89 to 47% in 2005/06, this increase remained substantially lower than that noted for other methods.

Ever use of modern contraception increased from 7% in 1988/89, 16% in 1995/96, 37% in 2000/01, and 42% in 2005/06 (P<0.001). Significant method-specific increases in ever use of modern contraception were noted for injectables (from 1.3% in 1988/89 to 27% in 2005/06, P<0.001), and pills (from 5% in 1988/89 to 14.4% in 2005/06, P<0.001). Ever use of Norplant and IUD remained below 1% over the years, while ever use of female sterilization as a modern method of contraception increased only slightly from 0.8% in 1988/89 to 2.4% in 2005/06.

Current use of modern contraception increased from 3% in 1988/89, 8% in 1995/96, 14% in 2000/01 and 19% in 2005/06 (P<0.001). Significant method-specific increases in current use of modern contraception were noted for injectables (from 0.4% in 1988/89 to 10% in 2005/06, P<0.001), pills (from 1.1% in 1988/89 to 2.9% in 2005/06, P=0.001) and female sterilization (from 0.8% in 1988/89 to 2.4% in 2005/06, P=0.001). Current use of Norplant remained low (0.3% in 2000/01 and 0.4% in 2005/06) as was current use of IUD which remained at 0.2% over the years. Modern methods of contraception were more likely to be used by women aged between 25-44 years, those living in urban areas, those with primary or higher education, and those with at least 2 living children.
Conclusion: Modern contraceptive prevalence rate increased only slightly among currently married women despite almost universal knowledge of modern contraception and close to 20 years of active family planning promotion in Uganda. These findings suggest a need for innovative, target-specific family planning promotion strategies to increase the proportion of currently married women who use family planning services in Uganda.

G06: Emergency Contraception: Prospects and Practice

**Time:** Tuesday, 17 November 2009: 11:30am - 1:00pm

G06: 1

L’introduction de la contraception d’urgence (CU) en milieu scolaire permet‐elle l’adoption de comportements à moindre risque en matière de sexualité ? Étude pilote dans une structure scolaire de Guédiawaye (Dakar – Sénégal)

Mohamed Diadihou1, Thierno Dieng2, Fatou Bintou Mbow3, Youmané Faye4, Jill Keesbury4, Jean Charles Moreau5

1Centre Régional de Formation et de Recherche en Santé de la Reproduction, Senegal; 2Population Council; diadihoumohamed@yahoo.fr

1. Contexte

La situation sanitaire au Sénégal reste préoccupante, marquée par un fort taux de mortalité maternelle (401 décès pour 100 000 naissances vivantes), entre autres indicateurs défavorables. Cette situation est liée à la faiblesse de la prévalence contraceptive (10,3% - EDS 2005), pourrait être évitée grâce à un meilleur accès des femmes à des services de PF de qualité et à une bonne information sur l’utilisation des méthodes contraceptives modernes, y compris la Contraception d’urgence (CU).

Par ailleurs, alors que la population du Sénégal est très jeune (plus de 50 % ont moins de 20 ans et que les 15 – 24 ans représentent près du quart de la population urbaine au Sénégal (22.8 % - EDS 2005), les adolescents et les jeunes adultes ont jusqu’à là été peu concernés voire marginalisés par les programmes de Planification Familiale. Ce qui les expose au risque de grossesses non désirées, dont les corollaires constituent, dès lors, un problème de santé publique.

2. Hypothèse principale

L’orientation des lycéens âgés de 15 à 24 ans et de leurs enseignants associée à la formation des prestataires de soins permet, d’une part, d’améliorer leurs connaissances et attitudes et, d’autre part, de créer un environnement favorable pour la prévention des grossesses précoces et non désirées, par un meilleur accès aux produits contraceptifs, y compris la CU.

3. Méthodologie

Il s’agit d’une recherche opérationnelle qui s’est déroulée au cours de l’année 2008 dans un lycée mixte de 4000 élèves, situé dans un district sanitaire de la banlieue de Dakar, capitale du Sénégal. Les établissements de santé satellites du lycée étaient aussi concernés par cette étude. La stratégie adoptée comportait une enquête préalable, une intervention et une enquête finale. Les personnes enquêtées étaient sélectionnées sur la base de la parité dans le genre et de la qualification professionnelle (enseignants, lycéens, médecins, sages – femmes, pharmaciens, etc.).

L’intervention comportait deux volets :

- l’un consistait à former les prestataires de santé de la zone d’intervention en matière de CU et à promouvoir un accueil de qualité à l’égard des élèves en demande de services liés à la contraception en général et à la CU en particulier ;
- le second, en cours, vise l’orientation des enseignants et de leurs élèves pour renforcer les connaissances et attitudes de ces derniers sur les comportements à moindres risques en matière de sexualité et sur la contraception, CU comprise.

L’ensemble des données issues de l’enquête de base comme de l’enquête finale a fait l’objet d’une analyse de contenu thématique approfondie.

4. Données

Concernant l’enquête de base, trente cinq (35) interviews et quatre (4) focus group ont été réalisés. Elle a confirmé l’ampleur du problème des grossesses non désirées et ses conséquences désastreuses (redoublement, exclusion ou abandon des études) sur la vie scolaire des filles, ainsi que le besoin d’information de tous les acteurs au sein du lycée en matière de contraception.

Pour des raisons de calendrier, l’enquête finale a été restreinte aux seuls prestataires. Elle a concerné un échantillon de 13 prestataires de santé préalablement formés. Elle a permis de vérifier le renforcement effectif des capacités des agents de santé sur la CU et d’apprécier les changements de comportements de ces derniers à l’égard des adolescents / jeunes.

5. Conclusions

La CU constitue une réponse intéressante à la faible couverture des besoins non satisfaits en planification familiale. Cette approche centrée sur les élèves des lycées pourrait constituer un moyen pour améliorer la santé des adolescents au Sénégal. Par ailleurs, cette intervention pourrait servir de modèle pour une éventuelle extension aux autres districts sanitaires et établissements d’enseignement secondaire du Sénégal.

6. Contribution aux connaissances

Cette expérience, parce qu’elle s’est appuyée sur les représentants au niveau local du Ministère de la Santé et du Ministère de l’Education, a renforcé la nécessaire collaboration entre les différents acteurs pour une meilleure prise en compte des besoins en santé des adolescents et des adultes jeunes. Elle a renforcé les capacités des enseignants et pairs éducateurs permettant l’appropriation des modules de formation. Elle a renforcé également celles des praticiens de la zone d’intervention et permis une meilleure compréhension des problèmes de santé des adolescent(e)s / jeunes dans le district.

G06: 2

Understanding Supply Chain Barriers to Emergency Contraception in South Africa

Priya Nanda
ICRW, India; pnanda@icrw.org

Background and rationale

The urgent need for emergency contraception in South Africa is a consequence of an unmet need for contraception, high rates of unwanted pregnancies, and gender inequitable practices such as violence and rape. The South Africa DHS suggests that among 15-19 year old sexually active women, the use of contraception is low, with 44.2 per cent using some form of injectable contraception and 37.7 per cent using the male condom. The rate of teenage pregnancy is high in South Africa with 27.1 percent of women beginning childbearing by the age of 19 (SADHS, 2003). Many of these pregnancies are not planned and 79.2 per cent of births among mothers aged 15-19 are unwanted at the time of delivery.
In South Africa, emergency contraception is available at no cost and without a doctor’s prescription in public facilities in the form of an off-label formulation of combined oral contraceptives (COCs). A dedicated EC product has been available in the country since 1997 although it is more expensive and therefore not available in the public sector (Smit, McFadyen et al. 2001) (Maqhayi et al., 2004). A dedicated progestin-only EC product has been available in private pharmacies in the country since 2000 and can be purchased by users directly from pharmacists without a prescription (McFadyen, Smit et al. 2003; Maqhayi, Smit et al. 2004).

Previous studies of EC in South Africa have shown that the knowledge and use of EC are low despite its availability and potential benefits. Among South African women, 19.6 per cent report at least some knowledge of EC, but only 0.2 per cent of sexually active women aged 15–19 report ever having used EC.

Hypothesis

The analysis presented in this paper explores how and to what extent emergency contraception is being optimally supplied and used in in South Africa. The hypothesis is that information asymmetries along the EC supply chain from manufacturers, stockists, retailers, to providers create obstacles to effective provision of EC to women thus affecting the transformative potential of EC in terms of improving choice and access.

Methods

Qualitative data was collected through semi-structured interviews with key stakeholders knowledgeable about the production, distribution and sale of emergency contraception in South Africa. Respondents included: five government health department representatives, six representatives of the pharmaceutical industry, and two pharmaceutical wholesalers. Government respondents included representatives of the South Africa National Department of Health and the KwaZulu-Natal Department of Health.

Data was also collected from 32 providers of EC (including private-sector pharmacists and public health care providers) and 75 contraception clients through semi-structured interviews.

The value chain analysis of the reproductive commodity was identified as being uniquely suited as a framework that integrates the three focus areas. The analysis is based on data collection from the top end of the supply chain with key manufacturers, down through an expanding set of wholesalers and retailers, to an end point of the selected users in the study, will answer the following broad questions:

- What factors determine whether the commodity penetrates the market in both the public and private sectors?
- What are providers’ attitudes and perceptions towards EC?
- What is the relative distribution of the commodity through different types of providers?

Findings

At the ‘top end’ of the supply chain it is evident that the position of EC within family planning programs is highly ambiguous at best. The fact that EC receives strong policy support in South Africa and an appropriate EC formulation is widely available at the facility level notwithstanding, the reality on the ground for potential EC clients in South Africa is bleak. The time constraints experienced by public health workers and the lack of support for EC training has meant that the potential accessibility of EC products is not matched with the experience on the ground. Pharmacists are ill-informed about the required regimen and stock brands according to incentives given by the Pharmaceutical companies. Providers at private and public facilities suggest that although the awareness of emergency contraception is increasing, its demand and use at public facilities is low. Providers at pharmacies report an increase in the number of clients visiting the pharmacy directly to obtain emergency contraception. Most of the clients requesting emergency contraception are often young people aged 18 to 24 years. Some of the pharmacist interviewed expressed reluctance to prescribe emergency contraception uniformly to all clients, and discussed the need to express discretion based on demographic characteristics of clients such as age, sex, as well as repeat users. Providers are limited in the amount of counseling that they can offer clients because the pharmacies do not allow for privacy and confidentiality. Public sector providers talk about optimal prescription practices such as manual examination while most of the use of EC happens over the counter at private pharmacies, without any examination

Conclusion: In the case of EC in South Africa, a potentially transformative reproductive health commodity has not realized its full potential, in part, because the political, regulatory and social context surrounding EC production, distribution and use has not been adequately considered.

**G06: 3**

**Dispensing Practices of Pharmacists relating to Emergency Contraceptive Pills in Ibadan and Lagos Metropolis Nigeria**

OluKunle Omotosho

College of medicine University of Ibadan, Nigeria; tosokunle@yahoo.com

**BACKGROUND**

Emergency Contraceptive Pills (ECPs) are hormonal means of preventing pregnancy following unprotected sexual intercourse. If taken within 72 hours of the act, ECPs reduce the risk of pregnancies by 75%. Use of ECPs is important in Nigeria where unprotected sex is widespread. Commercial pharmacies are important access points for ECPs because they are more readily accessible than clinics and they also work during the weekend when it is difficult to get other health workers. Few studies have been carried out among the pharmacists who dispense the drugs, how they dispense it and better ways of dispensing it.

**ACTIVITY TESTED**

This study assessed the knowledge, attitude, and dispensing practices relating to ECPs among commercial pharmacists in Ibadan and Lagos metropolis, Nigeria.

**METHODOLOGY**

The study was cross-sectional in design. Pharmacists who practiced in both pharmacy shops and Hospital provided data for the study. Quantitative method was used to gather data; 270 and 190 validated questionnaires were administered to pharmacists in Ibadan and Lagos respectively during the period of eight months. Of this number, 211 (145 in Ibadan and 66 in Lagos) consented to participate in the study. Data were analyzed using descriptive and inferential statistics.

**FINDINGS**

The mean age of the respondents was 38.8 (10.9) years. There were more male (57.3%) than female respondents (42.7%). Seventy two percent of the respondents practiced in pharmacies and 28% in hospitals. The (2.6) out of 18 points. No significant mean knowledge score of ECP was 8.9 (difference was found in mean knowledge score of male (9.9) ± 2.6) and female respondents (8.9) ± 2.8 (p=0.05). Pharmacists aged less than 40 years had mean knowledge score of 9.4 compared to older Pharmacists (8.3). Respondents who had practiced for up to 30 years had significantly higher score of 9.1, when compared to those with less years of practice (7.7) (p=0.05). The overall mean attitude score was 8.8 ± 2.7 out of 16 points. Most of the Pharmacists (79.1%) believed that it was their responsibility to dispense ECPs. Forty-three per cent of respondents had religious objection to the dispensing of ECPs and 46.9% had moral...
objection. Twenty-eight percent supported ECPs as over-the-counter drug. Seventy percent of respondents had ever dispensed ECP, 30% had never done so. Seventy-one percent of pharmacists had ECPs in stock at the time of study. More male (61.7%) than female (38.3%) had dispensed ECPs. No significant difference was found in dispensing practices of pharmacists in Ibadan (94.5%) and Lagos (93.9%) (p=0.05). Sixty-one percent felt there was need for training before a pharmacist could adequately dispense ECPs but only 17.5% had ever participated in such training. However, 65.9% signified intention to be trained given the opportunity.

LESSON LEARNED

Although majority of pharmacists dispensed ECP, their knowledge of the drug is limited, they held negative attitude towards dispensing the drug. There is need to upgrade their knowledge and influence their attitude to the dispensing of ECPs through training.

G06: 4

A preference for emergency contraception: The case of emergency contraceptive pill use by private sector clients in Ghana

Dawn Chin-Quee, Kelly L’Engle
Family Health International, United States of America; DChin-Quee@FHI.org

1. Background/Significance

Because emergency contraceptive pills (ECPs) have been shown to be an effective back-up method of birth control after unprotected sex, it was expected that increased access to ECPs would result in a decrease in abortion and pregnancy rates. That expectation has not been borne out by research. As a result, efforts to decrease unintended pregnancies turned to promoting the use of more effective methods among ECP users—an approach dubbed “bridging”, as it encourages women to cross over or transition from ECPs to ongoing contraceptive use. However, bridging from ECPs to regular contraception was not only viewed as a means of reducing unintended pregnancies, but also as an appropriate response to anecdotal accounts in several African countries that over-the-counter, pharmacy access to emergency contraceptive pills (ECPs) led to unintended and inappropriate use of the method (i.e., the pills were not being used for emergencies).

2. Research: State main question/hypothesis

A two-phase study was designed to test bridging of pharmacy-based ECP users to regular contraception in Accra, Ghana. The first phase tested the feasibility and likely success of a planned bridging intervention—co-packaging ECPs with regular oral contraceptive pills (OCPs) at the point of purchase. The second phase was designed to implement the planned bridging intervention.

3. Methodology (including location, setting, period, analysis approach)

In the first phase of the study, we conducted 24 in-depth interviews with pharmacy-based ECP users to evaluate women’s reactions to the proposed co-packaging of ECPs and OCPs, as well as to an informational brochure that listed the benefits of regular contraception and provided guidance for safe OCP use. In addition, 329 individuals—including men—were intercepted and 252 short surveys administered to eligible women to document the characteristics of these pharmacy-based ECP users in Accra.

4. Data (if relevant)

N/A

5. Findings

The information gathered by the surveys and in-depth interviews indicated that the co-packaging intervention as conceived would not work. For example, respondents had very little knowledge of contraception and often did not understand the difference between OCPs and emergency contraceptive pills. Some women said they would consider taking OCPs on a trial basis, but many more were happy with ECPs and would not switch. In many cases, male partners introduced women to and/or purchased ECPs for these women. The surveys revealed a pattern of ECP and other contraceptive use that should inform thinking and further action with ECP users: About 1/3 of participants identified ECPs as their main, but not necessarily their only method of contraception. An unanticipated and interesting finding was that as many as 70% of women who used a particular brand of ECPs routinely took one pill before and one pill after sex.

6. Research: State knowledge contribution

The findings from the first phase of the study provided valuable information on how women use ECPs, who influences their decisions, and insights into the type of women who may need help with decisions about contraception. For example, the fact that some women took ECP pills before and after sex, in conjunction with the finding that they readily expressed their preference for ECPs, indicates that there is a demand for a purely postcoital or periconital method of regular contraception. Thus, these study results also provided guidance on responding to the needs of women and exploring the development of new contraceptive methods. As a result of the findings from the first phase of the study, we decided not to move forward with the co-packaging intervention and to explore instead the role of men in women’s use of emergency contraceptive pills.

G06: 5

Use of Emergency Contraception among Married and Unmarried Women Aged 18-30 in Three Kenyan Cities

Gwendolyn Tate Morgan
African Population and Health Research Center, Kenya; gmorgan@aphrc.org

1. Background/Significance

Over the past two decades, Kenya has made significant advances in its efforts to expand awareness, availability and use of emergency contraception (EC). EC has been widely available through commercial channels since 1992, when Postinor was first registered and distributed in select pharmacies and health outlets. In 1996, the International Consortium for Emergency Contraception (ICEC) and its partners launched a campaign to broaden EC access in the country, strengthening private sector distribution networks and successfully registering Postinor 2 a year later.

In 2005, the Ministry of Health (MOH) demonstrated its commitment to expanding availability of EC by procuring 700,000 units of Postinor 2 for distribution in public sector facilities. Building on this momentum, Marie Stopes Kenya launched a program to socially market the Indian-manufactured EC product, Pregnon, in its affiliated clinics, helping to further diversify and expand the market.

Despite an increase in availability of EC over the past ten years, awareness and use of EC in Kenya remained relatively low as of 2005. According to the 2003 Kenya Demographic and Health Survey (KDHS), EC is the least known modern contraceptive method, with less than a quarter of all women (23.7%) identifying it as an option and only 2.8% reporting ever use. A survey of young women in Nairobi, conducted by the Population Council’s ECAfrique in 2005, found that 91%
of all respondents who had used EC procured it from private pharmacies. The study also found that while nearly 75% of young women (aged 14-25) in Nairobi knew of EC, only 8.7% reported that they or their friends had ever used it, and less than half of the respondents (43%) demonstrated correct knowledge of the appropriate timing and conditions for use.

2. Research Hypothesis

A qualitative research study was conducted in three cities of Kenya to examine the motivation, ability, and opportunities of current female EC users and to determine the perceptions of EC among sexually active female non-users.

3. Methodology

During February 2007, 64 qualitative interviews using a semi-structured, open-ended field guide were conducted with both married and single women aged 18-30 years who reported being sexually active in the six months prior to the interview. Only respondents who had ever heard of EC and who were at risk of an unwanted or mistimed pregnancy (eg, not pregnant, not currently using a modern contraceptive method, etc.) were included for interviews. Research field sites included both urban and peri-urban areas of three major Kenyan towns/cities: Nairobi, Nyeri, and Kisumu. Six (6) focus group discussions were also conducted with never users of EC.

4. Findings

- Users of EC fall in two broad categories: (1) those who have used EC only once, used EC as an emergency method, then switched to a regular method of contraception (the minority); and (2) those who used EC as a regular method of contraception (the majority). These include: single ladies who use EC every time they have unprotected sex and married women who lived away from their husbands.

- Majority of respondents exhibited considerable information about how and when to use.

- Nearly all women obtained EC from chemists - was mentioned as the only convenient place to obtain EC without hassles.

- Majority of married/unmarried respondents faced no difficulties or challenges obtaining EC from a chemist.

- Most of the respondents considered the price of EC to be affordable, especially compared to the cost of caring for a baby or having an abortion.

- Analysis of the data show that respondents are overconfident in EC’s efficacy in preventing pregnancy – they believe it works 100% of the time. Even in minority of the cases where EC did not work, the respondents were quick to attribute it to improper use.

- Respondents knew how to take EC but they don’t know how EC works (mode of action).

- With respect to concerns about EC use, women are primarily worried about future side effects (infertility, deformed children) as a result of repeat use.

5. Knowledge Contribution

Programs which seek to promote emergency contraception for prevention of unwanted pregnancies should first strive to understand the ability, opportunity and motivation of current EC users and never users in order to design more meaningful programs.

AO7: National FP Policy and Advocacy I

Time: Tuesday, 17 November 2009: 2:00pm - 3:30pm

AO7: 1

Helping Malian Parliamentarians Bridge the Gap Between Legislation and Implementation

Modibo Maiga1, Honorable Fanta Mantchini Diarra2

1Futures Group International, Mali, Health Policy Initiative; 2Malian Parliament; mmaiga@futuresgroup.com

Background

Mali’s National Assembly adopted a Reproductive Health Law in 2002 which demonstrated that Malian parliamentarians were willing to take the lead in promoting family planning in their nation. This decade parliamentarians have become the key to shaping the reproductive health sector and the USAID Health Policy Initiative (HPI) Task Order 1 has engaged these leaders in a process that connects them more closely with the health centers and issues they are attempting to regulate and influence.

Hypothesis

HPI began this activity with the hypothesis that there exist significant gaps between the laws governing reproductive health and the implementation of these laws.

Methodology

To investigate and to close these gaps HPI arranged for and accompanied leading parliamentarians to visit health centers and formulate solutions. HPI called this initiative "Parliament on the Road to Health Centers".

HPI trained key parliamentarians on how to translate reproductive health legislation into actions and results on the ground. This training prepared the parliamentarians to maximize the benefit of their visits to health centers, which were arranged by closely collaborating with the Parliament’s Health Commission and the Parliamentarian Network for Population and Development (REMAPOD). Parliamentarians who visited health centers shared their findings with other parliamentarians, technical experts within the Ministry of Health, and with REMAPOD. These parliamentarians also took this opportunity to give speeches to their communities about FP issues.

Findings/ Lessons Learned

During these visits parliamentarians and HPI discovered that despite the existence of legal price ceilings for various contraceptives, the prices charged at health centers often surpassed the ceiling. We discovered that family planning (FP) services were not a priority in most health centers and that interactions between parliamentarians and service providers raised the profile of FP services.

There was a realization that the government’s attempts to make FP accessible to all were not sufficient to reach many of the poorest members of society, the price of accessing these services remained a barrier to the poorest women. The importance of male engagement in raising demand for FP was also highlighted during these visits.
Finally we learned that advocacy is always indispensible to assure that laws translate into actions on the ground. The engagement of parliamentarians with service providers and communities constituted a powerful advocacy vehicle to illuminate the shortcomings of existing policies and to raise the profile of FP programs. For example, this parliamentary engagement led to the government agreeing to pay the salaries of one group of FP doctors working at the health center in Kondongou whose salaries had until then been paid by the community.

AO7: 2

Repositioning Family Planning in Rwanda: How a Taboo Topic Became Priority Number One, and a Success Story

Laura Hoemeke1, Julie Solo2, Sara Stratton3, Emile Sempabwa4

1IntraHealth International, Rwanda; 2Independent Consultant; lhoeke@intrahealth.org

1. Background/Significance

Rwanda’s population of an estimated 10 million is one of the most densely concentrated in Africa. Although some experts speculate that extremely high population density was a contributing factor to the country’s civil war and resulting genocide in 1994, a pronatalist culture, religious opposition and little government support made advances in family planning even more challenging in the years immediately following the conflict. Although the contraceptive prevalence rate (CPR) increased from 4% in 2000 to 10% in 2005, Rwanda had still not yet returned to pre-genocide rates (13% in 1992).

By early 2008, Rwanda’s contraceptive prevalence rate had increased to 27%, more than doubling in fewer than three years. How this significant increase came about can provide important lessons to other countries. In early 2008, IntraHealth International, supported by the Hewlett Foundation, commissioned a special study on Rwanda titled Family Planning in Rwanda: How a Taboo Topic Became Priority Number One.

2. Research: State main question/hypothesis

Program: State intervention/activity tested

Multilevel evidence-based advocacy and policy efforts have led to dramatic increases in the use of modern contraceptives in Rwanda. Starting in 2005, Rwanda began taking specific measures to support family planning as essential for poverty reduction and the development of the country through policy change and a nationwide multisectoral effort to promote the use of modern contraception. The government recognized the need to address population issues, so the policies were not imposed from outside but were embraced and supported internally. The country’s first ever national family planning policy was developed in 2005. The country’s locally elected district mayors signed performance contracts with Rwanda’s president starting in April 2006 holding them accountable to meet objectives (including family planning objectives), and the president declared family planning as a national priority starting in November 2006. Rwanda’s parliamentarians, also active in the cause, have a draft reproductive health law on the table supporting the rights of all individuals to free family planning counseling and services. Also, other important elements have contributed to improving service delivery in Rwanda: contraceptive security, in-service and pre-service training, on-the-job training, payment for health care providers’ performance, District Incentive Funds, family planning secondary posts and community-provider partnerships, among others.

3. Methodology (including location, setting, period, analysis approach)

To tell the story of repositioning family planning in Rwanda, we used two sources of information: 1) review of key documents, including government policies, surveys and project reports; and 2) interviews with key informants, including government officials, program managers and implementers, health providers and family planning clients. In-depth interviews were conducted with 35 individuals in Rwanda. We visited health centers, interviewed clients and conducted a group discussion with members of a community-provider partnership group.

4. Data

Thanks to the successful policy interventions, and efforts to ensure that family planning services are widely available in Rwanda, contraceptive prevalence increased significantly: from 10% in 2005, to 27% in early 2008 (Demographic and Health Survey).

5. Findings

It is impossible to isolate one factor as having the most impact in increasing CPR in Rwanda; a combination of efforts at all levels and within various sectors contributed to this historic increase in the use of modern contraception:

• Advocacy with political leaders with a focus on economic arguments is an effective approach to building political will so that policies are internally supported rather than externally imposed.

• An active parliamentarians’ group can be important at two levels: increasing support at the policy level; and sensitization and awareness-raising in the communities they serve.

• Coordination of partners supporting family planning should come from the government and is necessary for ensuring efficiency, effectiveness, national coverage and sustainable improvements. There should also be a national implementation plan that translates policy into practical, clear and measurable actions.

• Choice matters, and improved logistics systems are essential to ensure that choice is a reality.

• A decentralized training process—training a team of district-level trainers and using on-the-job training—facilitates national coverage and minimizes disruption to services. On-the-job training is an important training approach to ensure that all providers at a health facility are able to provide family planning.

• Groups to foster partnership between health providers and communities can be effective in bringing about changes in quality.

• Innovative methods of providing motivation and incentives for performance—including performance-based financing, performance-based contracts and District Incentive Funds—produce results but can be expensive. These projects should include exploration of how to transition to more sustainable systems of motivation over time.

6. Research: State knowledge contribution

Program: State lessons learned

The experience of successfully repositioning family planning in Rwanda has shown that dramatic results are possible within a short time with strong political engagement at the highest levels and with mechanisms in place to foster advocacy and ensure high-quality family planning services—at all levels.
A07: 3
The Success Story of Implementing Best Practices in Kenya
Violet Anyanga Bukusi1, Maureen Kuyoh1, Marsden Solomon1, Anne Njeru1, Colette Obunga-Allo2
1Family Health International, Kenya; 2Division of Reproductive Health, Ministry of Public Health & Sanitation; 3Futures Group; vbukusi@fhi.org

Background/Significance
In recent years, challenges have emerged for the Kenya national FP program. These include a stall in national contraceptive prevalence and a decrease in donor funding for family planning, as a result of diversion of available resources to address Kenya’s growing HIV/AIDS epidemic. This shift was a major setback for a program that had relied so heavily on international donors, and it affected the procurement of contraceptive commodities. The reduction in donor support, combined with a weak commodity logistics system, resulted in frequent shortages of contraceptive supplies and limited choice of methods for the clients. At clinics and other facilities offering contraceptive services in every province, most contraceptive methods were out of stock for most of 2003. The Kenya Service Provision Assessment (KSPA) Survey of 2004 found that the proportion of facilities offering any modern method of family planning had declined over five years from 88% to 75%. During this time, the TFR increased slightly, from 4.7 in 1998 to 4.9 in 2003 (KDHS).

Intervention
In 2004, the Kenya MOH formed an Implementing Best Practices (IBP) Country team under the IBP initiative of WHO. The team developed a common country performance goal as follows:
- In a bid to reduce the maternal mortality in Kenya, within 18 months, develop and implement an effective plan to:
  - a) Ensure that at least 60% of service delivery points of 8 districts have 3 months contraceptive commodities buffer stock
  - b) Increase family planning uptake by 5% in facilities within the 8 districts

The IBP Kenya Country team identified four areas of focus to address the performance goal: Advocacy; Capacity building; Demand creation and; Commodity logistics. Futures Group, in collaboration with FHI and the Kenya IBP Consortium, developed an advocacy strategy to respond to the request of the MOH and NCAPD for assistance to ‘reposition’ the FP programme and strengthen political commitment, public and financial support for Kenya’s RH programme in general. Capacity Building interventions included consolidating existing FP materials into one Contraceptive Technology Update (CTU) curriculum, conducting training sessions with service providers in the selected districts, and enhancing supportive supervision. Demand creation activities took place at the facility and community levels using a standard community orientation package on RH/FP and through a media campaign to allay rumors and myths.

Methodology
Routine service statistics data on FP uptake were collected and analyzed. Meeting minutes, reports from dialogue with parliamentarians and the process of developing the CTU were documented. Reports on training including participants trained were provided. Media tracking on listenership was provided by the respective media houses.

Outcomes
In 2005, the Kenyan government allocated KShs 200 million to the national reproductive health program, to be used to procure contraceptives, equipment and related services for the national family planning program. It was the first time in the country’s history that the national budget had ever included a line item for reproductive health services and contraceptives, making Kenya one of only a handful of countries in sub-Saharan Africa to make such a commitment. It has since been increased to 450 million.

424 service providers received FP CTU and logistics training and supervision. The initiative created awareness and demand for FP services and improved perception of FP in the communities. The ACQUIRE Project in Kisii and efforts by Jhpiego in Nakuru are a case in hand. Through this intervention knowledge and skills were updated among providers.

All districts reported no stock outs in at least 3 modern FP methods at any given time. Created awareness of value of timely data for decision making and district reporting rate went up from 38% to 71% although facility reporting remained low; moved from 16% to 20%. There was 38% increase in Family Planning uptake in all districts - way above the target of 5%.

Lessons learned
Success factors:
- Leadership by line government ministries/departments and involvement of Provincial Health Management Team (PHMT) and District Health Management Teams (DHMT) members from inception and throughout the process of implementation ensures ownership
- Partnership leverages resources, enhances support for the MOH, reduces competition and reduces duplication of effort.
- Need to pay attention to both supply and demand side of service provision

Barriers/gaps to success:
- Galvanizing support for the initiative was initially challenging
- Resource constraints - limited funding for the program resulted in drop out of some partners
- Strengthening the contraceptive logistic system to ensure contraceptive commodity security remains a challenge given perennial stock-outs at national level.

A07: 4
Three family planning policy options in low resource settings – the case of Niger
Malcolm Potts, Martha Campbell, Virginia Gidi
UC Berkeley, United States of America; paigeppassano.bixby@gmail.com

Background
Thirty-two African countries have population growth rates over 2.5%, and 12 over 3%. Niger represents extreme tension between rapid population growth, limited human capital and diminishing resources. The 2008 population of 14.7 million is projected to reach 53 million in 2050 (TFR 2050 3.8). The UN high
variant projection (TFR 4.2) is 59 million; low variant (TFR 3.2) is 47 million. The per capita income ($180: PPP $880) is one of the lowest in the world. Recent economic growth (approx 2%) is lower than the population growth (over 3.0%). Only 12% of the country can sustain rain-fed agriculture. Cereal output is falling. Water scarcity and degradation of land will increase with global warming. Thirty-six to 50% of children are malnourished. The school-age population will be eight times as large in 2050. Between 1992 and 2002 the share of the national budget devoted to education fell from 120 to under 10%. Desired family size is high. Only one in 10 uses any form of contraception. HIV prevalence is less than 1% and there will never be a generalized heterosexual epidemic. “The public health training system is already experiencing huge difficulties.” (World Bank)

Hypothesis

We hypothesize that family planning is a necessary intervention to slow rapid population growth in Niger. The policy literature on family planning relevant to the decisions governments, finance ministers and international donors and bankers must make can be divided into three broad groups. Each is strongly held and with little overlap between them. In a highly simplified form they can be summarized by three quotations. Pritchett (1994) asserts that “high fertility primarily reflects desired births and that couples are roughly able to achieve their fertility targets.” The second is that socio-economic development will drive lower fertility and in its most extreme form Hodgson and Watkins (1997) assert that that “family planning services should be provide within the context of comprehensive reproductive health programs that [have] enhancing health, not lowering fertility, as their fundamental objective.” The third policy option focuses on meeting the unmet need for family planning and asserts that “Access to contraception and safe abortion has lowered family size, even in illiterate communities living on less than a dollar a day.” (Bisby Forum, 2009). We hypothesize that logistic and cultural challenges, time-scale, cost and likely impact of each policy vary widely and that an evidence base selecting the most appropriate policy for future action is needed urgently.

Methodology

Demographic projections to 2050 and analyses of the long-term impact of reaching replacement level fertility by a particular date will be displayed. UN statistics and national data on economic growth, agricultural output and education will be combined with a literature from peer reviewed journals on cost-effectiveness, scalability and the timing of policy options. We will then use this data to screen carefully each of the three policy options in the Nigerien context.

Findings

An initial first look focused on education and family size finds that a Nigerien woman with secondary education country has an average of 31 percent fewer children. However, only 15 percent of women even have any primary school education and over the past decade the share of the government budget going to education has fallen from 15 to below 10 percent, and the number of primary school classrooms has decreased due to lack of upkeep and unavailability of teachers. In 2000 there were 26 doctors, 13 pharmacists, 1,128 nurses and 334 midwives in Niger and, as noted above, little progress seems likely in training sufficient health personnel to keep pace with population growth. The hypotheses that families will access family planning without external assistance or family size will fall as a result of economic progress, and the option of making family planning available “within the context of comprehensive reproductive health programs,” will be explored in greater detail, but on initial examination they seem to be unachievable. It seems that the most plausible hypothesis is that greater attention needs to be given to focused family planning efforts to compliment other development inputs.

Lessons learned

Decisions by governments, finance ministers and international donors and bankers on investing in family planning are part of a much larger picture of economic development. An evidence base for choosing between a free market approach policy, a broad socio-economic approach, or a focused family planning policy for lowering family size in low resource settings with high population growth rates needs to be constructed. Achieving any reduction in poverty or feeding the population from local agriculture in low resource settings in parts of sub-Saharan Africa is going to be exceedingly difficult, but an essential and inescapable element will be a new, large-scale emphasis on focused family planning.

B07: Contraception and Abortion II

Time: Tuesday, 17 November 2009: 2:00pm - 3:30pm

B07: 1

Contraceptive counseling and use after second trimester abortion in South Africa

Daniel A. Grossman1, Naomi Lince2, Jane Harries3, Debbie Constant3, Marijke Alblas4, Kelly Blanchard5

1Ibis Reproductive Health, United States of America; 2Ibis Reproductive Health, South Africa; 3Women’s Health Research Unit, University of Cape Town; 4Independent consultant; dgrossman@bispreproductivehealth.org

(1) Background/Significance: In South Africa, second trimester abortion up to 20 weeks is legal for medical and social indications. Despite gains since legalizing abortion in 1996, there remain barriers to access, leading to a high proportion of second trimester terminations (25%-30% of abortions are second trimester). Most second trimester abortions in South Africa are performed by medical induction (MI) with misoprostol alone, but in some places dilation and evacuation (D&E) is performed. Post-procedure contraception provision is a critical element of abortion care.

(2) Hypothesis or Intervention/Activity Tested: We aimed to describe the prior family planning experiences of women undergoing second trimester abortion and the family planning methods received post-abortion, identifying possible areas for increasing uptake and user satisfaction.

(3) Methodology: Between February and July 2008, we performed a cross-sectional, observational study of women age 18 or older seeking abortion between 13 and 20 weeks gestation at five hospitals around Cape Town (3 D&E sites, 2 MI sites). Women were consented prior to the procedure. Clinical information was obtained about the procedure, and women were interviewed in English or Xhosa after recovering from the procedure. For the analysis presented here, we focus on findings related to contraceptive use before and after the abortion.

(4) Data (if relevant): Data prospectively collected as described above.

(5) Findings: 471 women were approached, 398 were willing to participate, and 304 were eligible and enrolled. 220 women underwent D&E, 84 underwent MI. Participants’ median age was 25 years, median parity was 1, and median education level was grade 12. Eleven women (4%) reported having had a prior abortion. Fifty-four women (19%) reported never using a method of family planning in the past; 42 (78%) of those who had never used contraception before were 25 years old or younger. Of the 234 women reporting prior use of contraception, 83% reported ever use of contraceptives, 20% reported ever use of oral contraceptives, and 6% reported ever use of condoms for family planning. Only one woman (0.4%) reported prior use of an intrauterine device (IUD). At the time of the interview, all but two women said they planned to start a family planning method; one woman said she had an allergy to contraceptives and another cited the attitudes of hospital staff as the reason why she did not plan to start a method. 239 (79%) of the women said that someone had talked to them about contraception before their procedure, and 142 (47%) said someone had talked to them about contraception since their procedure had ended. At the time of the interview, 256 women (89%) reported they had received a method, 5 (2%) had not, and 28 (10%) believed they would be receiving the method
before they were discharged. Of 253 women reporting the method they received, 88% received an injectable, 8% received pills, and 4% received an IUD. More women undergoing MI received an injectable compared to those undergoing D&E (93% of MI clients vs. 86% of D&E clients), while D&E clients were more likely to receive oral contraceptives (5.6% of MI clients vs. 8.8% of D&E clients) or an IUD (1% of MI clients vs. 5% of D&E clients). Of note, of the ten women who received an IUD, nine of them underwent D&E at the same site (43% of the women undergoing D&E at this site received an IUD); the remaining woman who received an IUD underwent MI.

(6) Knowledge Contribution or Lessons Learned: In this setting, uptake of contraception after second trimester abortion was almost universal; however, most women received injectables or oral contraceptives—methods they had used in the past. In addition, some did not receive either pre- or post-procedure counseling on method choices. At one site, 43% of women undergoing D&E had an IUD immediately inserted, a procedure that has been demonstrated to be safe and effective. Rather than simply focusing on any contraceptive method at the time of abortion, more effort should be focused on counseling about and provision of the full range of contraceptive options available post-abortion, including long-term methods such as the IUD and subdermal implants.

B07: 2

A comparison of induced abortion, spontaneous abortion, and ectopic pregnancy gynecology patients in Ghana

Hilary Megan Schwandt1, Andrea Creanag1, Richard Adanu1, Kwabena Danso1, Tsirì Agbenyega2, Michelle Hindin1

1Johns Hopkins Bloomberg School of Public Health, United States of America; 2University of Ghana, Korle Bu Teaching Hospital; Accra, Ghana; 3Kwame Nkrumah University of Science and Technology School of Medical Sciences; Kumasi, Ghana; hschwand@jhsph.edu

Background/Significance

In regions of the world where safe induced abortion services are not publically available due to the law, misinformation about the law, or safe abortion services are either nonexistent or not publicized despite the legal status of the procedure; women are admitted to hospitals at alarmingly high rates for treatment of unsafe induced abortion complications. Despite the liberal abortion law, unsafe abortion continues to be an issue in Ghana. Unsafe abortion was the leading cause of maternal death over four years at a rural district hospital in northern Ghana. According to a national needs assessment performed by the Ghana Health Service, abortion related deaths are responsible for 22 to 30% of all maternal deaths, thus making complications from unsafe abortion the largest contributor to maternal mortality in Ghana.

Little is understood about the pathways to unsafe induced abortion in Africa; specifically, how women and men in partnership navigate decision-making from an unwanted pregnancy to a pregnancy termination. Research has shown that the greater the gender stratification in a society, the greater the male’s fertility influence. In line with this research, African males, Ghana inclusive, are recognized as the head of the household and decision-makers in regards to fertility. Furthermore, in this setting women’s fertility intentions were shown to be affected by their male partner’s intentions while the reverse was not true.

The objective of this study was to identify the relationship, individual, and socio-demographic characteristics of women who have induced abortion complications, as compared to women who have spontaneous abortion or ectopic pregnancy complications, and to explore correlates of pregnancy disclosure among women with induced abortion complications.

Hypotheses

This study aims to identify correlates of women with induced abortion complications among all women being seen for pregnancy-related complications at the two largest teaching hospitals in Ghana. We focus on relationship characteristics to better understand the context in which women choose unsafe abortion in a country where abortion is legal. We explore two hypotheses:

1) Induced abortion complication patients are more likely to report they are the main decision-makers on household and family planning use decisions as compared to women who had other pregnancy-related complications.

2) Women who have induced abortion complications are less likely to report pregnancy disclosure to their male partners as compared to women who had other pregnancy-related complications.

Data and Methods

Gynecology patients from two urban Ghanaian teaching hospitals, who were admitted due to pregnancy complications, were included in the study. The majority of women had spontaneous abortions (73%; n=441), followed by induced abortion (20%; n=119), and ectopic pregnancy (8%; n=48). Analysis was done by unadjusted and adjusted multinomial logistic regression as well as multiple variable logistic regression.

Findings

Induced abortion complication patients were more likely to report making household and family planning use decisions (RRR = 1.18) as compared to spontaneous abortion patients. They were also more likely to refrain from disclosing the incident pregnancy to their male partner (RRR = 5.16). As compared to patients who reported a spontaneous abortion, women with induced abortion complications were more likely to report no religious affiliation, and a consensual union or single union status.

Nondisclosure of the most recent pregnancy among the induced abortion sample was only a quarter of the sample, but among the spontaneous abortion and ectopic samples it was only 5% to 6%. Nondisclosure among the induced abortion sample was more likely among those who reported they make the household decisions (RRR = 1.50) and less likely among the induced patients who were in a consensual union (RRR = 0.24).

Knowledge Contribution

Even in the context of legal abortion, women require postabortion care in Ghana. Women with induced abortion complications have a distinct set of characteristics in comparison to women who have spontaneous pregnancy terminations, such as: they are more likely to make general household and family planning use decisions, less likely to be married or to identify with a religion, and are more likely to hide the incident pregnancy from their male partner.

Understanding the profile and relationship characteristics of the typical induced abortion complication patient is the first step toward targeted programs and policies aimed at reducing unsafe abortion in this critical population.

B07: 3

Characteristics of women seeking abortion-related services in Addis Ababa, Ethiopia

Yilma Melkamu1, Tsefaneh Belay1, Ndola Prata1, Martine Holston2, Tesfaye Endrias1, Lense Gobi1

1School of Public Health, Addis Ababa University, Addis Ababa, Ethiopia; 2Venture Strategies for Health and Development/DKT Ethiopia, Addis Ababa, Ethiopia; 3The Bixby Center for Population, Health and Sustainability, School of Public Health University of California, Berkeley, United States; 4Venture Strategies for Health and Development, United States; mholston@venturestrategies.org
Background: In Ethiopia, which has one of the highest rates of maternal mortality in the world, 30% of maternal deaths are abortion-related. While access to safe abortion is gradually increasing in Ethiopia following the revision of the criminal code in 2005 and the development of abortion series guidelines by the Ministry of Health, services are not yet widely available throughout Ethiopia. Country-wide, the total fertility rate is still very high (5.4), close to one third of births are either mistimed or unwanted, and there is a huge unmet need (34%) for family planning. However, Addis Ababa has experienced rapid fertility decline, and now has below-replacement fertility with a total fertility rate of 1.9. A third of married women in Addis Ababa are using a modern method of contraception compared to only 6% country-wide. Despite having greater access to family planning services, many pregnancies are still unwanted or mistimed, and one in five women have an unmet need for family planning (39%). The high demand for abortion-related services points to its role in the fertility decline of Addis Ababa.

Activity Tested: The purpose of this paper is to investigate the characteristics of women seeking abortion-related care to inform the development of national guidelines and policies on abortion in Ethiopia.

Methodology: We analyzed the service statistics of 1,200 women seeking safe abortion or post-abortion care from October 2008 to February 2009 in three public and three private health facilities in Addis Ababa, Ethiopia. We also conducted in-depth interviews with five abortion-care providers to illuminate the contextual factors of abortion service provision in these clinics.

Findings: Examination of the socio-demographic characteristics revealed that overall most women seeking abortion-related care during the study period were young, well-educated, and single. The mean age of women requesting services was 25, and 79% of women were aged 20 to 29. Fewer than 5% of women were under 18 or over 36. Women were fairly well educated, with 75% of women having secondary education or above. More women were single (52%) than married (44%). However, women seeking post-abortion care were more likely to be older (26 vs. 25), married (77% vs. 34%), and less educated (57% reaching secondary or above vs. 79%) compared to women seeking safe abortion.

While women had an average of 2.2 pregnancies, the average number of live births was 0.8, indicating the role of abortion in fertility control. A third of women had a previous abortion. Mean number of abortions of women who had had at least one previous abortion was 2.3, including the abortion sought at the time of the study. Over half of the women had ever used family planning. Previous contraceptive utilization is lower among the young women and those who have reported ever use have used contraceptive methods inconsistently.

More women came to the health facilities seeking safe abortion (82%) than post-abortion care (18%). Almost all safe abortions occurred within the first trimester (96%); average uterine size was 8 weeks. A contraceptive method was provided to 86% of women; most commonly pills, injectables, and condoms.

Family planning services are not provided during duty hours.

Provider interviews confirmed that the majority of services at these facilities are abortion-related and that the socio-demographic characteristics of women and services sought differ between public and private facilities. Perspectives on the burden of unsafe abortion varied by the type of health facility the provider works at, from being a rare case in private facilities to constituting most of the abortion-related client load in public facilities. All mentioned that while repeat abortion is common, there has been a significant decline in the magnitude of complications due to unsafe abortions. Providers indicated socio-economic differences in service-seeking behavior: the urban middleclass women come at an earlier gestational age and are more likely to have used family planning. Lack of awareness, use-failure, and dependence on abortions were reasons providers gave for low family planning use among the young.

Knowledge contribution: In order to best serve women seeking abortion-related services, policy-makers in Ethiopia should focus their efforts on reaching single, poor, and young women and rejuvenate family planning efforts to reduce repeat abortions.

B07: 4

Improving Quality of Abortion Services in Vietnam

Phuong Nguyen, Ton Van der Velden, Ngo Thuy Nga
Pathfinder International Vietnam, Viet Nam; npvphuong@pathfind.org

1. Background/Significance

Abortion has been legal in Vietnam since 1945 and services have been available on request since the early 1960s. To assist the Ministry of Health (MOH) in reducing the need for abortion services and to improve the safety and quality of services provided, the Reproductive Health Projects (RHPs), a partnership among Pathfinder International, Ips, and EngenderHealth, has worked with the Central MOH and with eight provinces throughout the country since 1994.

2. Research: State main question/hypothesis

Program: State intervention/activity tested

The purpose of the program is to address the safety and quality of abortion services provided in Vietnam’s public sector. The project has built provider capacity in clinical abortion care (including MVA and more recently, medical abortion), abortion counseling, and promotion of postabortion family planning in eight provinces, while achieving a wider scale impact by supporting the MOH to disseminate a national training curriculum in RH (14 modules) as well as establishing an in-service training network through which quality training on safe abortion is widely provided.

3. Methodology (including location, setting, period, analysis approach)

The RHPs, now operating for more than 15 years, combines high quality clinical training with training follow-up and facility upgrades to ensure that providers continue to practice at the level they were trained. The program established and institutionalized MVA supply channels within the country. In addition, introduction of quality supervision, including clinical observation and coaching, monitoring client satisfaction, and analysis of service statistics has allowed the project to ensure sustained outcomes. Given the high quality training capacity developed in the eight original provinces, trainers from these provinces now offer training in safe abortion and other RH topics to public sector RH Care centers in neighboring provinces.

4. Data (if relevant)

5. Findings

Safe abortion services (both MVA and medical abortion) are now widely available in the RHPs provinces. MVA has replaced all D&C procedures for first trimester abortions. Service utilization increased in all eight RHPs-supported provinces by 40% between 1999 and 2005 and the postabortion contraceptive utilization rate is now very high--82-99.8%—compared with MOH estimates of less than 10% nationally. In three additional neighboring provinces where staff received abortion training provided by the RHP pilot sites, the impact on quality of abortion is promising. In one province MVA entirely replaced D&C. In the three provinces, the postabortion contraceptive rate has increased on average from 39.1% in 2006 to 94.2% in 2008. In client interviews in all eight RHPs-supported provinces, 80% of women report that they were treated respectfully by the medical staff that cared for them.
Sustainability of the project achievements has been an explicit aim of the RHPs. Successful advocacy efforts have resulted in commitment from the eight provincial governments to contribute provincial budgets for the routine purchase of MVA supplies and equipment. Training teams are available in all eight provinces capable of providing competency-based training on MVA and medical abortion using the national RH training curriculum.

Despite these successes, there are aspects of the project that need further attention. For example, there is a continued need for promotion of effective, longer term methods postabortion. Acceptance of condoms postabortion increased significantly from 40% in 1998 to nearly 65% in 2006 (not including condoms as part of a double method). This raises concerns for risk of repeat abortions since condoms are less effective in preventing pregnancy than LMTs. It also raises questions concerning whether or not clients are receiving proper counseling concerning method mix, risks and benefits, and informed consent when choosing a method. A Pathfinder commissioned study assessing the factors influencing postabortion condom acceptance found that incomplete and biased counseling (“young, unmarried people should use condoms”) as well as client preference based on characteristics, such as age, marital status, education, and communication and support of the partner were factors. Young people have been targeted by media messages making condoms more popular, and women with a supportive partner who would comply with condoms were likely to choose them.

6. Research: State knowledge contribution
Program: State lessons learned

Provision of quality abortion services helps to respond to clients' needs and rights. A comprehensive package including training, supervision, facility support, and advocacy for sustainability was effective in improving the quality of care of abortion services in Vietnam in a sustainable way. It remains important to monitor and improve quality indicators such as the post abortion contraception acceptance rate and the method mix of acceptors.

B07: 5

Addressing Morbidity and Mortality from Unsafe Abortion: Assessment of Safe Abortion and Contraceptive Service in Ethiopia
Tibebu Alemayehu¹, Joan Healy¹, Karen Otsea², Selamawit Dagne³, Janie Benson¹
¹Ipsas (Ethiopia), Ethiopia; ²Independent Consultant; ³TRHB, alemayehut@ipas.org

1. Background/Significance

Reducing high rates of maternal mortality in developing countries has been a focus of major international efforts for over 20 years, and remains an important and immediate goal through MDG 5. However, attention to unsafe abortion, which causes 13% of these deaths globally, has received less attention, despite proven interventions for preventing and reducing these deaths. The Safe Abortion Care (SAC) model, adapted from the Emergency Obstetric Care approach, is a package of services (contraception and safe abortion to prevent and manage unwanted pregnancy, and prompt and proper treatment of abortion complications) and tools for monitoring and measuring the implementation of these interventions. The SAC model assumes that if the package of services are available, well-utilized and of sufficient quality, maternal mortality will decline.

2. Program: State intervention/activity tested

Ethiopia has a high maternal mortality ratio of 673 per 100,000 live births, with unsafe abortion accounting for as much as 32% of these deaths. In addition, the low contraceptive prevalence rate (14%) and high unmet need for family planning services (40%) expose women to a very high rate of unwanted pregnancy and abortion in Ethiopia. In order to reduce the tragic consequences of unsafe abortion, the Ethiopian law on abortion was changed in 2004 to allow access to safely induced abortion for rape, incest and physical or mental disabilities of the woman. Subsequently, in 2006, the Ethiopian Ministry of Health published technical guidelines for safe abortion services, and efforts have been underway in Tigray and other regions of Ethiopia to improve and provide the expanded abortion care services including postabortion contraception. A particular focus has been to ensure that all women seeking abortion-related care also receive contraceptive counseling, and that a full range of methods (including long-term and permanent methods) are available in the location where treatment of abortion complications and safe abortion services are provided. Over the past two years, the SAC monitoring approach has been used to track progress in the delivery of these services in the Tigray region of Ethiopia (population 4.5 million). This paper will report on the results from Tigray.

3. Methodology (including location, setting, period, analysis approach)

The two-year project was conducted in all 50 public health facilities (12 hospitals and 38 health centers) in Tigray and consisted of the following components: 1) baseline assessment of SAC performance in the 50 facilities; 2) orientation to the SAC approach for staff from all facilities; 3) monitoring and supportive supervision visits to the facilities; and 4) endline assessment of the 50 facilities’ SAC progress. Which are done in addition to efforts in training providers on abortion care and equipping facilities with MVA.

4. Data (if relevant)

Obstetric and abortion logbooks were the primary source of information on the caseload of women seeking abortion-related care. In addition, monitoring visits included reviewing service information with key providers and facility administrators and discussing facility level action plans and efforts undertaken to improve services.

5. Findings

Preliminary analysis of some the final results are shown in the table below.

Preliminary findings from select indicators for measuring Safe Abortion Care in Tigray Region, Ethiopia (n=50 facilities)

(6 months of data)

- Proportion of women who received abortion services that received induced procedures 168/2301 (7%) 1336/2331 (60%)
- Proportion of uterine evacuations performed with appropriate technology 579/2018 (29%) 1746/2144 (81%)
- Proportion of women who received abortion services who left facility with contraception 709/2301 (31%) 1746/2231 (78%)

In addition at baseline, 17 of the 50 facilities had performed all of the necessary "signal functions" to be considered as offering adequate SAC services. This number had increased to 38 out of 50 by the endline visit. These preliminary findings suggest that marked improvements have occurred among the facilities in the availability of SAC services (signal function increases), in utilization (increase in safe induced abortion) and quality (increase in use of appropriate technologies and uptake of contraceptive methods), suggesting that abortion-related maternal mortality is declining in Tigray.
6. Program: State lessons learned
The SAC approach has been an important tool for tracking progress on implementing the FMOH mandate to deliver abortion care services including postabortion contraception. Making contraceptive methods available to women seeing abortion care is an evidence-based intervention to reduce repeat unwanted pregnancy and unsafe abortion. Even women who experience spontaneous abortions benefit from counseling on the health risks of bearing many children and the need for child spacing. Too often, however, abortion services and contraceptive provision are not linked at health facilities. The demonstrated improvements in postabortion contraceptive services in Tigray are also strengthening health facility capacity to provide contraception for all women attending the health facility, not just those women receiving abortion-related care. Continuing to link contraceptive and abortion-related services will make a significant contribution toward achieving the FMOH's goals for increasing overall contraceptive prevalence in Ethiopia and reducing maternal mortality.

C07: FP Financing
Time: Tuesday, 17 November 2009: 2:00pm - 3:30pm

C07: 1
Global Fund Financing of Condoms and Contraceptives for Reproductive Health Commodity Security
Nadia Olson, Dr. Fidele Ngabo
1USAID | DELIVER PROJECT, United States of America; 2Rwanda Ministry of Health; nolson@jsi.com

1. Background/Significance
Recently, attention has been focused on strengthening linkages between reproductive health (RH) and HIV/AIDS programs. Advocates have drawn attention to the benefits both programs would receive from increased integration. Experts have also been arguing that the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) should support reproductive health (RH) programming—specifically, RH commodities including contraceptives. The Global Fund has become increasingly supportive of approaches that strengthen links between RH services and HIV/AIDS programs. This support has gradually translated into the use of GFATM financing to increase support for procuring condoms and other contraceptives.

2. Main question/hypothesis
a. What is some of the evidence for integrating reproductive health and HIV programs?
b. What are the implications of new developments at the Global Fund for efforts to strengthen reproductive health commodity security at the country level?
c. How has GFATM and local support for integrated programs translated into increased financing for procuring both condoms and other contraceptives?

3. Methodology
A series of research and policy briefs have been developed to help assess and publicize the extent to which the GFATM supports increased integration of RH and HIV programs. Beginning with an analysis of the GFATM Price Reporting Mechanism (PRM) database, the first brief in the series assesses the extent of the Global Fund’s financing of condoms. Next, the series reviews and publicizes support from the global level for increased integration and procurement of contraceptives in countries applying for GFATM support. The third brief in the series documents how global support was then applied in one country—Rwanda—to generate increased financing for procuring contraceptives.

4. Findings
Research shows that between 2005 and 2007, the GFATM was already an important financing source for both male and female condoms worldwide, some reportedly used for family planning. For this period, the Global Fund financed 561.6 million male condoms and 5.2 million female condoms. For male condoms, the amount financed has steadily increased from 152.5 million in 2005 to 194.8 million in 2006, which is a 22 percent increase over 2005; and to 214.3 million in 2007, which is a 29 percent increase over 2005.

In addition to Global Fund financing of condoms, advocates for integration between family planning and HIV programs have made concerted efforts to ensure country-level stakeholders are aware that GFATM funds can be used to procure contraceptives. The Global Fund has clearly indicated that it will use its grants to support countries that are financing the procurement of RH commodities if linkages are made to disease outcomes—in this case, HIV prevention.

Finally, a significant step for both contraceptive security and HIV prevention in Rwanda, local Global Fund stakeholders have decided to fund contraceptives by providing a three-year commitment worth more than U.S.$2.4 million from Round 7 Funds. Global Fund financing has been used in the past to finance condoms in a number of countries, but it is believed that Rwanda is the first country to fund contraceptives as part of its efforts to fight HIV and AIDS.

5. Knowledge contribution
A number of new developments at the Global Fund have implications for efforts to strengthen reproductive health commodity security, which is the ability of clients to choose, obtain, and use RH products and services when and where they need them.

C07: 2
Vertical Provisioning of Family Planning to Rural Communities—Time for a Rethink?
Gopi Gopalakrishnan, Karen Pak Oppenheimer
1World Health Partners, India; 2Venture Strategies for Health and Development, USA; gopi@dkinternational.org

1.Background/Significance
A large share of the estimated 20% unmet need for family planning is due to the lack of access to modern methods. Most seriously affected are communities living in rural and interior areas who constitute 70% of the developing world’s population. World Health Partners believes the only way to reduce both the extreme imbalance between need and response, and the continuous dependence on donors is by using private entrepreneurial energies. These, however, can be triggered only by bundling and delivering family planning services with health.

2. Hypothesis of Intervention/Activity Tested
If private entrepreneurial energies are to be tapped for delivering services to rural and vulnerable communities, their profit expectations cannot be met with family planning services alone.

Operational research needs to be concurrent with day to day programming, as opposed to post-facto. This enables effective administration, quicker decision-making and agility to adjust to uncertainties.
3. Methodology

Facilitating, for the private sector, ability to deliver economically attractive curative care with far less attractive family planning services as part of a single non-negotiable package is at the core of WHP’s operational strategy. It divides service delivery needs into smaller components and matches them with competencies that are available close to the clients; when not available, refer clients to a higher level of care while continuing to provide counseling and support services. Each component is an integral, efficient part of an operation providing support, services, and referrals to others. All members earn not only for providing care, but also for facilitating care through WHP partners and affiliates—from local rural health providers and pharmacies to regional franchisee clinics and diagnostic centers. An additional revenue stream comes from assisting WHP-organized services and events. The WHP model also utilizes public-private partnerships to draw on public sector resources such as nurse midwives, government-run clinics, training facilities, etc. The public sector, however, needs a strong output validation mechanism to financially support service provision. WHP is currently helping the government develop a biometric system which, after a trial, will be scaled up to the whole country.

In November 2008, WHP launched its pilot project in 1,000 villages in three underserved districts of Uttar Pradesh state in northern India. An estimated 3.6 million people live in this project area, of whom 2 million reside in rural and remote villages. Using state-of-the-art satellite and computer technologies, the project links qualified city-based doctors with patients living in remote settings. Such connectivity enables strong value addition to rural providers who, as a prerequisite to stay as network member, needs to provide family planning. The connectivity also enables an automated real time monitoring whose statistical rigor is strengthened by its link with a monetary system. Market research from clients also validates each provider. An efficient supply chain and sophisticated data management system completes the project.

The pilot project healthcare network consists of 1,000 Sky Care (rural health) providers, as well as 100 Sky Health Telemedicine Centers, 12 franchisee clinics, 4 diagnostic test laboratories, and 1,400 rural pharmacies. A Central Medical Facility based in New Delhi is staffed by formally qualified doctors and specialists and provides or supervises all medical services. The Sky Care and Sky Health Centers handle clients for minor care—such as small injuries and fever, over-the-counter products, dipsticks tests like pregnancy detection. More difficult cases are referred to CMF for therapeutic care or to the franchisee doctors for surgical care. The franchisee doctors also consult with specialists in CMF to improve their diagnoses. Medical algorithms and records available electronically improve the quality of care.

5. Findings

The results of such a strategy are instant and dramatic. Within three months of starting operations, the project has provided 59,700 couple years of protection averting an estimated 34,115 unwanted pregnancies. This increases couple protection in the area over time by 37%, from 28 to 38.3.

6. Knowledge Contribution and Lessons Learned

Vast private sector resources are available in rural and vulnerable parts of the developing world but vertical programming of family planning services will not fulfill the minimum acceptable profit needs of the providers. Combining family planning with health meets providers expectations, invites investments, creates a more positive environment for users, and enables project managers to enforce quality norms. Competencies and skills exist at different locations and they need to be interlinked through a strong administrative and real time data management system to produce optimum results.

C07: 3

Ensuring availability and coverage of social marketed family planning products in Nigeria: Findings from Measuring Access and Performance Survey

Samson Babatunde Adebayo, Richard Fakolade, Chinazou Ujuju, Oladipapo Banji Ipadeola

Society for Family Health, Nigeria; sadebayo@sfnigeria.org

Background

Social marketing of family planning products in Nigeria focuses on the poor and vulnerable population. Programmers in time past relied on distribution survey which uses sales data to inform the spread of these products to the target population. This method, however, does not identify areas of poor coverage. Furthermore, reliability on volumes of sales data alone (which is the focus of distribution survey) was not appropriate to estimate places where people have need for these products and services. As a consequence, an approach that addresses issue of coverage of products and services is desirable. This paper presents findings from a Measuring, Access and Performance (MAP) survey conducted on family planning products in Nigeria. This was aimed at ensuring availability and wider coverage of family planning products to the target population.

Activity Tested

The Society for Family Health (SFH) has conducted MAP study since 2005 on a yearly basis. The last round was in 2008. Each finding shows areas where the coverage of SFH family planning products and services are required but has not been adequately reached or covered according to set targets or standard. Similarly, results also help to improve on coverage and quality of coverage indicators for family planning products and services in areas where although minimum standards have been reached, coverage and quality of coverage will have to be regularly improved and sustained. The study has thus been useful for the sales and distribution department including programmers, in setting and improving on the minimum standards for each family planning products and services.

Methodology

MAP study uses GIS and Lot Quality Assurance techniques to estimate coverage and availability of health products. SFH uses this method to identify areas of poor coverage with the aim of increasing the availability and coverage of social marketing product and service delivery systems in the country. This is to ensure contraceptive security and reduce the unmet need. In this instance, coverage in MAP survey is defined as the proportion of localities in which a minimum level of family planning product/service availability was present.

Nineteen (19) localities were selected and visited in each of the six (6) geo-political zones of Nigeria resulting in a total of 114 localities visited nationwide. These localities were selected based on probability proportional to size (PPS) after the ordering of the geographical locations of Nigeria localities. Lists of localities in Nigeria which formed the sampling frame were provided by the National Population Commission (NPC).

Data

Simple audit sheets were used to collect information on coverage and quality of coverage indicators from outlets in the selected 114 localities in the country. A Global Positioning System (GPS) device was used to record the exact geographical coordinates of each outlet visited, which were later plotted on the map of Nigeria. The audit sheets were developed based on the information needed for calculating coverage and quality of coverage indicators. Data collected through the audit sheets were processed in SPSS. The interpretation of results was based on Lot Quality Assurance Sampling (LQAS) decision rule.
Findings
Coverage of five contraceptive products (Duofem, Postinor-2, Depo-provera, Noristerat and Male Condom) was assessed in all the six geopolitical zones of Nigeria in August 2008, after a similar study was conducted 12 months earlier. Results showed that between this reporting period (August 2007 to August 2008), coverage increased for some products in some zones. Significant improvement was noticed for zones where some products previously recorded low coverage. For instance, coverage of oral pills: Duofem and Postinor-2, increased in the South East, North Central, South West, South South, and North West zones. Similarly, there was an improvement in the coverage of condom in the North Central and North East zones. Conversely, for Injectables: Noristerat and Depo-provera, coverage dropped in South South and North East zones between this reporting period.

Knowledge Contribution
MAP results shows areas where coverage will have to be sustained and improved. This information can be vital for the sales and marketing teams in prioritizing their efforts and extending products and services to areas where people have need of them. Less emphasis needs to be placed on places where high volumes of sales can be achieved. In doing so, the performance of the social marketing programs will improve in terms of health impact, change, cost-effectiveness, equity, and efficiency.

CO7: 4
Are Contraceptive Implants Finally Affordable to Programs?
Barbara Janowitz, John Bratt, Kate Rademacher, Markus Steiner
Family Health International, United States of America; bjanowitz@fhi.org

1. Background/Significance
Despite high effectiveness and acceptability, contraceptive implants have played a relatively minor role in the method mix of most countries. However, demand for implants has been high in places where they have been made available. The main barrier to broader use has been high up-front cost relative to many other methods. While the upfront costs for implants are high, the average cost per year of use declines as duration of use increases. Ministries of Health and donors would benefit from information on "fully-loaded" costs of different contraceptive methods to guide decisions about types and quantities of commodities to purchase.

Literature on contraceptive costs in developing countries focuses primarily on service delivery costs, including commodities, supplies, labor and capital. Comparisons of service delivery cost per couple-year of protection (CYP) favor the IUD, with its low commodity cost and relatively high CYPs per unit. Using this information, decision-makers might concentrate their commodity budgets on IUDs assuming that the method with the lowest service delivery costs is the most "cost-effective." But focusing only on service delivery costs may be misleading, because they exclude the costs of demand creation, which can be very high for methods like the IUD, and lower for an implant because of the high unmet demand. In addition, costs of training are likely higher for long-acting methods than for resupply methods and should be factored into comparisons of method costs.

2. Main challenge
There is a need for a new cost indicator that includes the costs of all resources needed to generate "effective use" of a method. Such an indicator would expand upon costs of service delivery to include costs of demand creation, training, supervision and other factors to be identified. A major challenge will be to generate valid estimates of the costs of generating demand for methods where demand creation is necessary to stimulate acceptance.

3. Methodology and Data
We used data from the 13 USAID Office of Population and Reproductive Health Priority Tier 1 Countries (DR Congo, Ethiopia, Kenya, Madagascar, Malawi, Nigeria, Rwanda, Tanzania, Uganda, Zambia, India, Pakistan, Haiti). We calculated the direct cost per CYP for IUDs, COCs, two types of injectables (DepoProvera and a generic DMPA) and three implants (Jadelle, Implanon and Sino-implant (II)). Direct cost included the commodity cost, costs of any disposable supplies used at the initial visit, and costs of clinician labor associated with initial visits, follow-up visits and discontinuation visits (where applicable). RH Interchange provided information on commodity costs, and the RH Costing Model (United Nations Millennium Project) provided data on clinician salaries and time inputs, disposable supplies and follow-up patterns for the long-acting methods. USAID standard CYP conversion factors were used to convert direct costs into direct cost per CYP by method. Using these data, we will explore and compare different methodologies for adjusting direct cost per CYP to include costs of training as well as demand creation, where appropriate. We will also examine how costs are modified by select characteristics of users, for example, by pregnancy intention (spacing versus limiting) which may modify duration of use and impact CYP.

4. Findings
The median Direct Cost per CYP across the 13 USAID Priority Tier 1 countries is lowest for the IUD ($1.64) and highest for Implanon ($13.03). The median Direct Cost of CYP for DMPA-generic DMPA, combined oral contraceptives (COCs) and Jadelle are similar (ranging from $7.90 to $8.70). The median Direct Cost per CYP for Sino-implant (II) is $4.02. We will present data showing how these relative costs are modified by consideration of other factors including training, supervision, and demand generation costs.

Discontinuation rates are a key influence on cost per CYP for implants. Long-term use leads to higher cost effectiveness for methods with high up-front costs. However, even with shorter durations of use, costs are competitive with shorter term methods, particularly for the newer Sino-implant (II). These results indicate that the implant can be a cost-effective method for women who want more children and want to space them three years apart, the recommended interval for healthy spacing of births. Thus, analyses will take into consideration whether women desire additional children in determining cost effectiveness of methods.

We will include recommendations for future research and methods development to improve the way in which countries and programs make decisions about contraceptive procurement.

5. Knowledge contribution
While the up-front costs of some implants may be higher, our analysis shows that the three available implants are all cost-competitive with other methods, whether evaluating Direct Cost per CYP or "Fully-loaded" Costs per CYP, and whether considering shorter or longer durations of intended use. Given the high effectiveness and acceptability of implants (measured by high demand in countries where it is available), expanding implant procurement should be a direction considered for all programs.

CO7: 5
Social Marketing and DKT
Phil Harvey
DKT International, United States of America; phil@dktinternational.org

Although government programs are still the largest family planning service providers in many countries, the contraceptive needs of poor populations are increasingly being met by a wide variety of independently managed contraceptive social marketing (CSM) programs and by a growing number of commercial contraceptive suppliers. In 2007, social marketing programs served the contraceptive needs of 40.2 million couples in 67 countries and provided hundreds of millions of condoms for HIV/AIDS prevention. This contribution means that social marketing programs accounted for about six percentage points of contraceptive prevalence in the developing world (excluding China), and roughly 20 percent of the birth spacing methods used by couples in developing countries.

All major contraceptive methods are included in the social marketing effort. In 2007, social marketing programs sold 152 million cycles of oral contraceptives, 24 million injectable doses, 750,000 IUDs, two billion condoms, and emergency contraceptives, female condoms, implants, and spermicides. A few social marketing campaigns promoted sterilizations. Manual vacuum aspiration (MVA) kits for first-trimester abortion (and related purposes) were also sold in small numbers, and this category is growing. Social marketers are also becoming interested in misoprostol, which, because of its multiple uses, can be introduced even where abortion is restricted.

The growth of social marketing services has been both steady and rapid, increasing from 4 million couples (4 million couple years of protection as measured by standard CYP conversion factors) in 1985 to 14 million in 1995, and to 37 million in 2005. Social marketing remains one of the very few low-cost and quickly scalable approaches to delivering birth control, particularly spacing methods, to widely scattered populations in the developing world.

DKT International

DKT International is the largest provider of family planning social marketing services and, combined with Populations Services International (almost as large) reaches about 30 million couples of the 40 million (2007) social marketing total. DKT’s program’s, which place a particular emphasis on the financial aspect of social marketing, include 11 countries (India, Brazil, China, Egypt, Ethiopia, Indonesia, Malaysia, Mexico, the Philippines, Sudan and Vietnam), addressing a substantial portion of the world’s population. Those programs, like social marketing overall, have grown rapidly from 3 million CYPs in 1998 to 17 million last year.

Poverty and Income

DKT’s impact is greatest in the lowest income countries where we operate, and, expectedly, the revenue generated in those programs is lowest. In Ethiopia and Sudan, our programs are providing, respectively, 13 and 8 percentage points of prevalence. In these relatively low prevalence countries this means that the DKT programs are providing nearly half of all of the spacing methods available in those markets. At the same time revenue generation from the sale of contraceptives is less than $2 million per year in Sudan and Ethiopia as against more than $12 million in Brazil and Indonesia, and more than $15 million in the Philippines. Fortuitously, the growing surpluses from Brazil, the Philippines, and Indonesia can be put to use— albeit on a modest scale so far—to help subsidize the programs in the lower income African programs.

Distribution

As to logistics and infrastructure in Africa, social marketing responds well. Wherever beer or cigarettes, or branded foods or other consumer goods can be found, socially marketed contraceptives can also be supplied. In the remotest areas of Ethiopia and Sudan this still leaves out some of the hardest-to-reach rural villages, but it includes the vast majority of the population. That is one of the secrets of social marketing. Where logistical systems are weakest, the strongest systems are usually the commercial ones. Entrepreneurs and business people are remarkably imaginative at finding logistical pathways to the largest possible numbers of customers. Social marketing, by taking advantage of those networks, can vastly expand the reach of family planning programs.

On the financial side, DKT’s 12 programs this year will generate about $60 million in revenue, sufficient to cover two-thirds of all program expenses. If per-capita GNI continues growing in the developing world as it has in the past decade, it should be possible to maintain and expand this brand of family planning delivery with a gradually diminishing demand outside on donors.

D07: Addressing the FP Needs of People Living with HIV I

Time: Tuesday, 17 November 2009: 2:00pm - 3:30pm

D07: 1

Improving Family Planning Choices for People Living with HIV in Zambia

Uttara Bharath Kumar1, Peter Chabwel2, Carol Underwood2, Lynn Lederer1, Hilda Banda1, Jane Brown2

1Health Communication Partnership Zambia; 2Johns Hopkins University Bloomberg School of Public Health, Center for Communication Programs; uttarabkk@hcp.org.zm

Background/Significance: ZDHS 2007 estimates: Zambian HIV prevalence at 14.3% (meaning about 1.5 million people are living with HIV/AIDS); 16% of pregnant women are HIV positive; and 40% of babies born to them will be infected without PMTCT intervention. Family planning (FP) uptake is 41% but there is a 27% unmet need for family planning (ZDHS 2007).

In 2006, HCP conducted a qualitative study of FP and HIV Integration looking at how fertility-related decisions are influenced in high HIV prevalence settings. The desire for fertility was high even among HIV positive individuals. However there were low levels of information about family planning and fertility choices available to those who are HIV positive. There were also many misconceptions about family planning methods interfering with effectiveness of ARV therapy.

Intervention/Activity: To address identified information gaps, HCP, and key stakeholders (PLHIV, MOH, NAC and other technical experts), developed a documentary-style video, “Our Family, Our Choice” (OFOC) supported by a Facilitators’ Discussion Guide and Client Booklet. OFOC looks at how HIV positive couples can use FP methods to avoid pregnancy or wait till they are physically, virologically and emotionally ready to have a baby. It dispels myths about FP methods being unsuitable for those on ART and gives couples a balanced view of their options without biasing their decisions.

Methodology: OFOC is available in English plus 7 Zambian languages. 3,000 copies of the film and Guides and 20,000 of the Booklet were distributed to facilities across the country that provide VCT, ART and/or PMTCT services for viewing in clinic waiting rooms. OFOC was also distributed to private clinics, NGOs, workplaces, and mobile video units to screen in rural areas.

Findings: From the eager reception during pre-testing, launch, distribution and national TV broadcast on WAD 2007, lack of information about FP in Zambia is evident and people are hungry for it. In the words of one of the viewers, “I thought I could not use family planning since I am taking ARV medicines but now I have seen that there are people who have done so. The nurse was especially clear in how she advised the couples.” Mutinta Phiri, Kanyama (2007).
Sexual and reproductive health needs and preferences of people living with HIV/AIDS (PLWHA) in Southern Nations Nationalities and Peoples Region (SNNPR)

Assefa Seme Dereasse1, Kekebe Debeko2

1SPH Addis Ababa University, Ethiopia; 2SNNP Regional Health Bureau; assefaseme@gmail.com

Abstract:
Background: Sexual and Reproductive needs and preferences of HIV positive individuals are changing with the development and use of antiretroviral therapy (ART). Due to improvements of symptoms and signs and the change in the quality of life after ART, PLWHA regain their normal sexual activities with various reproductive needs and preferences. This became both an opportunity and new challenges.

Objective: The aim of this study is to assess sexual & reproductive needs and preferences of PLWHA who are receiving antiretroviral therapy (ART) in five Hospitals of Southern Nations Nationalities & Peoples Region (SNNPR).

Methods: A cross sectional survey was conducted from February to March 2007 on 461 patients receiving ART in five hospitals of SNNP with a response rate of 98.5%. Data on sexual and reproductive needs and preferences were collected using structured and pre-tested questionnaire. Data entry and analysis was done by using SPSS for Windows version 14. Proportion was used to describe the study populations. Odds Ratio was computed to look into the strength of the association between dependent and independent variables. We run logistics regression to control for confounding variables.

Result: While 238 (52.4%) of the study participants were females 187 (41.2%) were in the age group of 25-34 years. About half (50.2%) were married while 85% of them had some form of education and 209 (46%) of the study subject were unemployed. Two hundred twenty three (49.1%) HIV positive clients reported having had sexual practices with regular partners while 191 (42.1%) have abstained. Twenty four (5.3%) reported sexual practices with no or inconsistent condom use while 16 (3.5%) had multiple sexual partners. About one-third (33.9%) of the respondents expressed their desire to have children. More than half 92 (53.7%) of those who desire to have a child wanted to have after two years. About seven in ten respondents (70.4%) reported ever use of at least one method of contraception and 33 (53.4%) reported intention to use at least one method in the future. Condom and injectable contraceptives are the most commonly used method of contraception in the past and preferred method to be used in the future.

Unmarried HIV positive individuals who had sexual partners practiced more risky sexual activities (AOR: 6.99, 95% CI: 2.34-20.9) compared to married ones. Alcohol users were practicing more risky sexual behaviors (AOR: 6.07, 95% CI: 1.87-19.7) compared to non users. Respondents in the age group 15-34 years (AOR: 1.91, 95% CI: 1.13-3.24), married individuals (AOR: 1.78, 95% CI: 1.05-3.14), those with risky sexual behaviors (AOR=1.73, 95% CI=1.02-2.95) and those who reported to have no alive children currently (AOR: 4.41, 95% CI: 1.46-13.36) were more likely to desire to have children.

Conclusion and Recommendation: Sexual & reproductive health needs and preferences of PLWHA are not affected by their HIV status. Risky sexual practices were not uncommon among the study population. The desire to have children was a driving force that made them exercise risky sexual practices. Significant number of those who desire to have a child wanted to postpone for the future. Unprotected sexual act, besides the resulting pregnancy that could compromise the immune system of PLWHA, could also expose them to new viral infection which can further lower their immunity. To help people avoid risky sexual practices such as unprotected sex and to address the need to postpone pregnancy, better approach in provision of counseling services to people living with HIV/ AIDS and condom promotion as a dual protection method is most advised.

Harm-reduction applied to reproductive health counseling for HIV-affected couples who choose to conceive children.

B. T. Matthews1, Angela Kaida1, Christina Psaros1, David R. Bangsberg1,2,3
1Beth Israel Deaconess Medical Center; Boston, MA; 2University of British Columbia; Vancouver, CA; 3Massachusetts General Hospital; Boston, MA; 4Harvard Initiative for Global Health; Boston, MA; 5The Ragon Institute; Boston, MA

1Background: As antiretroviral therapy restores health and increases life expectancy, couples affected by HIV face complicated choices between fulfilling reproductive desire and risking HIV transmission to their partners and children. Traditionally, HIV-affected couples are advised not to have children, but complex cultural, economic and social factors drive many couples to reproduce. Serodiscordant couples are common in sub-Saharan Africa where women comprise 60% of people living with AIDS and remain the fastest growing component of the epidemic [1]. The highest risk of contracting HIV lies within a marital relationship: Sero-negative partners within HIV sero-discordant couples face a transmission risk between 20-25% per year [2]. The frequency of transmission related to intentional procreation is unknown.

Longitudinal data show that HIV transmission risk, however, can be reduced to acceptable levels through artificial insemination and sperm washing [3] yet most HIV-affected individuals have neither economic nor geographic access to technical fertility resources. In the absence of counseling that recognizes the desire and importance of having children, couples may knowingly take on the risks of transmission in order to have children. Programs to reduce HIV transmission must explore a more nuanced, patient-centered approach to reproductive counseling.

2Hypothesis: We propose a harm-reduction approach to fertility counseling in HIV treatment care and services. The goal of a harm reduction approach is to first understand the fertility goals of the couple, and then design strategies that both meet that goal and minimize risks to the couple and their child.

3Methodology: We carried out a substantive review of the literature seeking lower- and higher- technology strategies to reduce the risks of HIV transmission to a sero-negative partner among HIV-discordant couples in resource-limited settings where ART is available but technical fertility services, such as sperm washing, are not. Those which are effective at reducing harm are presented as a counseling protocol.

4Findings: Couples who wish to have children should be counseled about the risks to the unborn child, the mother (particularly if she is HIV+), and the uninfected partner. If, given a clear understanding of the risk, couples remain eager to have children, the options differ depending on which partner is infected. Patients should be counseled that HIV infection may mitigate fertility and that attempts at procreation may be unsuccessful. Subsequently, and as a priority, couples should be encouraged to wait until the infected partner is on ART with an undetectable viral load (where monitoring is available). If the infected partner has a sustained and suppressed viral load, transmission risk is close to zero. If the woman is infected, her ART regimen must exclude teratogenic ARV’s, including Efavirenz. In addition, both partners should have genital exams and be treated for any diseases that compromise mucosa. Couples should be also be
counseled in ovulation cycles and should be advised to engage in unprotected sex only during the fertile period of the woman’s monthly cycle. Timed intercourse will decrease the transmission risk simply by minimizing exposure.

If the man is HIV-negative with a positive partner, partners can be taught artificial insemination (AI), timed to the woman’s fertile period. If performed properly, AI should reduce risk to zero. Circumcision may minimize risk for female-to-male transmission, however artificial insemination remains the safest approach for these couples. For couples in which the woman or both partners are positive, the only real option is careful, informed natural conception. Peri-conception pre-exposure prophylaxis may offer additional options for risk reduction in the future.

Couples should be encouraged to share their plans with their providers in order to have close follow-up for routine testing, early detection, enrollment in prenatal and, potentially, PMTCT programs. Accordingly, providers should encourage such discussion by routinely asking patients about their fertility desires and intentions.

(5) Knowledge Contribution:

Simply encouraging HIV-affected couples to abstain from procreation is not a realistic strategy, particularly in communities and cultures where the importance of having children is emphasized and ART services are available. In the absence of counseling that recognizes the desire and importance of having children, couples may knowingly take on the risks of transmission in order to have children. In resource-limited settings our understanding of HIV transmission can be shared with our patients in a structured way to help mitigate new infections while affording patients more reproductive choice.


D07: 4

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

Monica S. Malta1, Catherine S. Todd1, Mark A. Stibich1, Thais Garcia2, Diego Pacheco3, Francisco I. Bastos1

1Oswaldo Cruz Foundation, Brazil; 2Columbia University, United States of America; 3Xenex Technologies, United States of America; cst2121@columbia.edu

Background: Brazil has offered ART at no cost through the public health system since 1991.1 Reversible contraception and sterilization are also publicly funded. However, contraceptive coverage remains an issue for HIV-positive women in Rio de Janeiro, where 6.9 pregnancies/100 woman-years occurred between 1996 and 2003 among HIV-positive women on ART.2

Hypothesis: HIV status is not the sole consideration determining contraceptive choice and discontinuation among HIV-positive women in Rio de Janeiro, Brazil.

Methodology: This qualitative study was conducted at Oswaldo Cruz Foundation, Ambulatorio da Providencia, and affiliated clinics within the Rio de Janeiro metropolitan area. Eligible participants were HIV-positive women between 18 and 40 years of age; participants were purposively selected into 3 groups: <22 years, 23-30 years, and >30 years.

Data: Participants completed a standardized questionnaire about ART usage, fertility history, partnership status, and contraceptive usage. Three focus group discussions (FGDs) (1/age group) were conducted to determine main themes, followed by 15 in-depth interviews (IDIs) to obtain further depth and explore themes. Transcripts were coded using grounded theory approach then grouped into themes. Coded quotations were analyzed for impact of various demographic factors on themes. Analysis was performed with ATLAS-ti (ATLAS-ti Center, Berlin).

Findings: There were 34 participants (19 in FGDs and 15 in IDIs) enrolled. Participants had 1.5 mean pregnancies; 12 women were pregnant at the time of interview. Median time since HIV diagnosis was 4 years, with 55.9% taking ART. The most common contraceptive methods utilized were condoms, either alone or with another method (n=21); female sterilization (n=11); and oral contraceptives (OCS) (n=10).

When listing known methods, condoms and OCS were the most familiar. Most participants had no experience with injectable contraception. Post-coital OCS were mentioned by a few as an alternative method or emergency measure. Some participants mentioned barriers to use of a specific method:

“...I would like to use those injections. Those that chicks take just once a month, but it’s expensive... My man used to pay for it, but it’s expensive you know. Now I use pills, but sometimes I forget to take them, then take two on the next day... It’s a big mess...” FGD 2E1, 25 years, 3 children.

Overall, participants believed condoms were the best contraceptive due to lack of side effects and protection from infection. However, some complained about lack of sensation and most participants that obtaining partner agreement was challenging, particularly in long-term relationships. Many participants also commented that their HIV status led them to choose condoms over other methods due to dual protection. The chief reason for discontinuation was partner refusal based on perception that asking for condoms indicated suspected infidelity.

Regarding OCS, many cited daily dosing and concerns about ART interactions as reasons for discontinuation. The longer duration of injectable contraceptives was perceived positively; however, this method, and, to a lesser degree, OCS were associated with undesirable side effects:

“There are a lot of side effects, you feel like your belly swells, you can have some cardiovascular diseases if you keep using them for a long time, and some studies even relate those contraceptives with breast cancer.” FGD3E3, 22 years, 1 child.

Discontinuation due to menstrual disturbances was rare; contraceptive amenorrhea was seen as positive, particularly by IDI participants. Some reported using OCS to delay menstruation to go to the beach or Carnival, a common practice for teenagers.

Sterilization was more common among older participants, with most stating satisfaction with the decision. Age did not otherwise alter perspectives on method choice or discontinuation. A few mentioned the physician’s role in their decision. Often physicians were reported as resisting the procedure because the participant was very young. Some women reported desiring sterilization and encountering financial or provider-mediated barriers, one of which was directly attributable to HIV status:

“He (the physician) said women using method don’t use condoms anymore, understand? He said many things I did not agree but... I don’t have money to do it on my own [in a private clinic], but I would like to do it.” IDI2MM, 36 years, 2 children.

Following sterilization, a few women expressed regret, usually linked to new partnerships. Though most participants stated that their fertility desire decreased with HIV diagnosis, a few women reported increased desire for future childbearing.

Knowledge Contributions: HIV status has some impact but is not the most important determinant of contraceptive choice among HIV-positive women in Brazil. Condom use is largely determined by partner preferences. Sterilization is highly desirable as means of limiting family size, but due to completed childbearing rather than HIV diagnosis. The large number of pregnant participants and dynamics in FGDs may have biased these results. Our findings emphasize that providers should consider many factors in contraceptive counseling, work with clients on condom negotiation strategies, and provide a range of methods to address changing needs throughout the reproductive lifespan.

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Factors Influencing Contraceptive Choice and Discontinuation Among HIV-Positive Women in Kericho, Kenya

Kennedy Imbuki1, Catherine S. Todd1, Mark A. Stibich2, Douglas N. Shaffer3, Samuel K. Sinei1

1Walter Reed Project Program, Kenya; 2Columbia University, United States of America; 3Xenex Technologies, United States of America; cst2121@columbia.edu

Background: Kenya has an established generalized HIV epidemic with infection occurring predominantly through sexual transmission. In Kericho District in Western Kenya, HIV prevalence among adults ranges from approximately 6-14% with some estimates in women as high as 19.1%, likely varying in part due to differing surveillance methodologies used and populations studied. Antiretroviral therapy (ART) has been widely available since 2004 and reversible contraceptive methods are available at no cost through government health facilities.

Hypothesis: Gender roles, tribal identity, and HIV status interact to impact contraceptive utilization among HIV-positive women in Kericho, Kenya.

Methodology: This qualitative study was conducted at the Kericho District Hospital and affiliated clinics in western Rift Valley Province of Kenya. Eligible participants were HIV-positive women between 18 and 45 years of age; participants were purposively selected into three groups: <22 years, 22-30 years, and >30 years.

Data: Participants completed a standardized questionnaire about ART usage, fertility history, partnership status, fertility desires and contraceptive usage. Three focus group discussions (FGDs) (1/age group) were conducted to determine main themes, followed by 15 in-depth interviews (IDIs) to obtain further depth and explore themes. Transcripts were coded using a grounded theory approach then grouped into themes. Analysis was performed with ATLAS-ti (ATLAS-ti Center, Berlin).

Findings: There were 47 participants (32 in FGDs and 15 in IDIs) enrolled. Participants had 2.3 mean pregnancies and 40.4% were married. Most participants reported familiarity with injectable contraceptives, the intrauterine device (IUD), and male and female condoms. Diverse cultural groups were present with some participants being familiar with (and confident about) traditional herbal preparations for both contraception and fertility restoration.

Many participants held medically inaccurate beliefs about fertility and timing of intercourse to avoid conception.

“Some conceive when they have intercourse during menses, others may not conceive during this time. Other women say that whenever they are on their menses it’s a must that they sleep in separate beds so that they don’t conceive, others prefer to sleep in one bed because during this time their libido is high so they sleep in one bed so that they can have sex with their partners.” #1033, <22 years, 1 child.

Other medically inaccurate beliefs included the idea that waiting a week after menstruation before resuming sexual activity would help prevent sexually transmitted infections (STIs) or that the IUD would prevent STIs.

Regarding gender roles, almost all participants reported they could not refuse sex with their partner/husband. Men were generally perceived to oppose contraception.

“For me, at first, my husband was not happy, he didn’t like the idea, he told his mother, who came and told me that she never used any methods. He would not allow me to go to the clinic. Even my brother in law was not happy when his wife went to the Family Planning clinic. Many men don’t like the idea.” #1021, age 27, 2 children.

The opinions of the male partner/husband impacted method choice. Men opposed condoms due to decreased sensation; hormonal contraceptives due to diminishing women’s libido and making sex less pleasurable; and sterilization due to its permanence. HIV diagnosis made some difference in these attitudes where women became more assertive about protecting themselves through abstinence, particularly widows:

“... I refused to be inherited because I could infect the other person who could inherit me. In my community people don’t know much about HIV/AIDS and when a person approaches me for a relationship, I tell them openly that I am infected with HIV/AIDS and they really fear me.” #1034, age 37, 2 children.

Women reported method discontinuation because of side effects (like back pain or low libido), having met their desired parity, and changes in menstruation. Among most participants, amenorrhea was not desirable because: the “dirty blood” would not get out; the husband/partner would know that birth control was being used; and, in Luo culture, a woman should not stop menstruating before her mother-in-law stops.

“When I used to experience menses I would feel very nice, I would not experience back or lower abdominal pains but when I started using Depo, now there is no that blood and I feel very bad.” #1033, 22 years, 0 children (2 died from AIDS).

Age and parity did not appear to affect contraceptive knowledge or perceptions about side-effects.

Knowledge Contributions: The concern for or opinion of the male partner plays a predominant role in contraceptive utilization decisions in Kenya. Cultural practices or beliefs may impair correct use of some methods, particularly periodic abstinence. Some beliefs, like fertility being highest during menstruation, may increase risk of HIV re-infection. The large number of widowed participants and dynamics in FGDs may have biased these results. Patient education of both men and women and public awareness campaigns to dispel inaccurate beliefs about available contraceptive methods may optimize utilization in this setting.

References:
E07: 2

Integrating Family Planning into Essential Maternal and Newborn Care in Northern Nigeria

Emmanuel Otolorio Otolorin, Samaila Yusuf, Elaine Charurat, Catharine McKaig
Jhpiego; rlu@jhpiego.net

1. Background

In 2006, a program was initiated in Kano State with the objective of increasing use of essential maternal and newborn care (MNH) services, including family planning (FP) as part of the household-to-hospital continuum of care approach, for pregnant women, mothers and newborns. As family planning was considered a highly controversial activity in Northern Nigeria, the program initially focused on MNH care with the intention of later addressing healthy timing and spacing of pregnancy and FP. FP was commonly called birth spacing in the intervention area.

The program has two major areas of activities, facility-level and community-level. At the facility level, key activities include training providers in MNH and an FP update. All trainings have been followed up by supportive supervision activities. At the community level, the program has formed community core groups representing the communities in the catchment area of the facilities. In 2007, female community household counselors were identified and trained to provide basic MNH messages at the household level for pregnant women through the first week after birth.

After two years of implementation, program monitoring data for MNH services in program sites indicate significant increases in service use, including antenatal care, delivery care, FP and modern method use. Client loads have increased an average of four fold in the five initial facility sites. This experience provided the opportunity to more systematically examine the mechanisms of effective MNH/FP integration.
International Conference on Family Planning: Research and Best Practices

2. Program
In order to better understand the mechanisms of integration, an assessment was undertaken in the program area. This assessment examined perceptions of policy makers, providers and community members with regard to integrated MNH/FP services as well as factors facilitating and negating the use of services. The assessment was informed by findings from the literature and examined their application in the program in Nigeria.

3. Methodology
A literature review was conducted in attempt to identify factors contributing to successful MNH and FP integration. While the review yielded little in terms of programmatic lessons learned, several recoursing themes were identified and incorporated into the methodology.

One-on-one interviews were conducted with six policy makers and eight service providers using semi-structured interview guides which incorporated themes from the literature. Group discussions were held which included participatory methodology with four women’s groups and four other community groups. The interviews and group discussions took between 60-90 minutes to complete.

4. Findings
The key findings from the assessment include five areas.

From the point of view of providers and clients, all services are not equal. It is clear that perceptions of the value of different services vary. Generally, antenatal care (ANC) was the most valued by providers and community members, although for different reasons. Providers see it as a gateway for other services, articulating the perception as the beginning of a cycle. Despite community level education regarding risks, women continue to view ANC as a protective service that reduces risks associated with pregnancy, delivery and postpartum.

It was disappointing to note that labor and delivery were not ranked high by either service providers or women. Only the household counselors ranked labor and delivery as well as antenatal care highly. Family planning was generally ranked lower or lowest by policy makers, providers and the women’s groups, with a few exceptions.

The approach of incorporating FP into routine MNH was well accepted by providers and policy makers. Increases in client satisfaction and increases in service use (particularly that of FP services) were attributed to the systematic integration. In fact the providers more frequently offered examples of the benefits that they see from integration. This is a finding of particular note in this conservative setting.

Women did not appear to be daunted by the relatively complex service schedules. In every site they easily cited the service schedules in some detail. They also noted the positive attitudes of the staff and cited barriers in terms of cost and transportation for services.

Barriers for integrated services included the issue of staff time identified by policy makers and providers. Interestingly, the four women’s groups also said they preferred to have services on different days because otherwise the queues would be too long. Other barriers to services cited by respondents included cost, transportation, religion, education and clients husbands.

5. Knowledge contribution
While the assessment had significant limitations, it did demonstrate the utility of systematically reviewing MNH/FP integration. The tools used will be further modified and adapted for application in other settings to improve understanding of effective MNH/FP integration. The findings from this assessment indicate that an approach which systematically increases MNH/FP integration is feasible and can have a positive effect on service use, particularly FP, even in a very conservative environment.

E07: 3
Meeting the RH Needs of the Marginalized Urban Population in Kenya
Pamela Lynam, Jane Otai, Stuart Merkel, Daniel Nguku
Jhpiego, United States of America; rlu@jhpiego.net

1. Background:
By 2030, according to the projections of the United Nations Population Division, more people in the developing world will live in urban than rural areas; by 2050, two-thirds of its population is likely to be urban.

The urban poor, often living in informal settlements (slums) are different from the rural poor, our usual partners. Development programs and approaches have not yet caught up with this reality, and sometimes traditional approaches do not work in the urban slums. Slum communities are divided along lines of age, religion, and ethnicity – but there is a greater heterogeneity among slum communities than rural; therefore traditional tribal values and peer pressures are far less evident, and need a different approach.

2. Program:
We used the Performance and Quality Improvement approach, traditionally used for healthcare facilities and service providers; adapted this to the community; and brought service providers and communities together to identify their own health problems and possible approaches to them - rather than imposing our own pre-formed programmatic approach.

3. Methodology:
We worked in two Nairobi slums, Korogocho and Viwandani, from 2007 to 2008, with funding from the Wallace Global Fund. Our reproductive health program built on the previous experience of the Nairobi Urban Health and Poverty Partnership, (ed by APHRC, and partnering with Jhpiego, PATH and Nairobi City Council, over the past 5 years, funded by the Rockefeller Foundation.) Apart from a needed access to FP, there were many issues mentioned by the community and the health providers.

4. Contact the authors for results.

5. Findings. Programmatic lessons learned:

A. COMMUNITIES
Reaching a given slum community requires developing different approaches for different groups. For instance, we found that contrary to conventional wisdom, urban young people do not want to be reached by older, ‘wiser’ clinicians. Young urbanites want to hear about family planning from their peers – so we helped start a youth CBD program. Likewise, Muslim groups want to hear from other Muslims.

Training community leaders does not necessarily mean that the entire slum population is reached.
Traditional Birth Attendants continue to play a vital role in the community, providing advice and referrals. We should include them more in FP provision and enlist them as CBDS.

PQI is program-participant driven. Therefore, the program may not have anticipated interventions beforehand – making planning and budgeting a challenge. The nature of funding for this program enabled Jhpiego to carry out activities that were not planned, but were identified as needs. Key examples are the request for a post-rape program; providers were trained in post-rape care, and the community trained in self-defense "I'm worth defending" and in para-legal issues around rape. Also, the community requested cervical cancer screening, 23 providers were trained, and hundreds of women have been screened by the Visual Inspection method. While neither of these activities were planned, they served two purposes: 1.) addressing real healthcare needs, and 2.) empowering communities and providers to identify and be key stakeholders in their own healthcare.

B. SERVICES:

Service providers (SPs) need good training, supplies and tools for the job. Even a small amount of funding to ensure they have basic supplies improves confidence and motivation – and community confidence - thereby increasing service use.

Supportive supervision motivates providers. While this program targeted RH and FP, the whole clinic improved when supervisor offered support and updates.

Improving data reporting is essential, and training –short and practical – has to be provided for this.

Trainings for both SPs and communities are more successful when trainees know they will be used as resources in other knowledge sharing and training forums.

Support groups have been viewed primarily for sick people, but we found that enabling a group setting for providers reduces stress, and keeps motivation high. This has not only benefitted providers but has also destigmatised the concept of support groups.

C. BRINGING IT ALL TOGETHER

Finally, bringing together providers and communities has had other benefits. Increasing confidence and respect for each other enabled one clinic to give its waste ground to the community to grow nutritious foods such as sukuma wiki. In turn the community volunteered their time to re-paint the clinic. Increased confidence improves attitude, and use of services. This unique program is breaking ground in addressing issues of urban health. Jhpiego looks to replicate this program and document best practices for widespread scale up in the future.

E07: 4

Integrating Family Planning and PMTCT Services in Morogoro, Tanzania

Chrisostom Lipingu, Maryjane Lacoste, Elaine Charurat
Jhpiego; rlu@jhpiego.net

Background:

In Tanzania, it is estimated that 8.2% of pregnant women on the mainland are HIV-positive (National AIDS Control Programme). Ongoing prevention of mother-to-child transmission of HIV (PMTCT) services are largely focused on counseling and testing for HIV during antenatal care (ANC) with some emphasis on intra-partum treatment. Little emphasis has been placed on postpartum/postnatal care for women and their infants, regardless of their HIV status. While ANC effectively serves as a platform for initial PMTCT, there is no similar postnatal platform to facilitate care for women and infants after delivery. Examination of the 2005 Demographic and Health Survey data indicates that 62% of women at the end of the first year postpartum have an unmet need for FP, with 18% wanting to limit and 44% wanting to space their next pregnancy.

Working with the Ministry of Health and Social Welfare, a new program is establishing a model for the provision of comprehensive postnatal care services for HIV-positive and HIV-negative postpartum women and their infants. This will be accomplished both through health systems strengthening and through outreach to the community. The program is currently being implemented initially in the Morogoro Region of Tanzania, with plan for subsequent scale-up based on lessons learned. In order to document the baseline situation and to inform the design of interventions, an assessment was conducted in 2009 which examined the status of postnatal care, as well as postpartum FP.

Methodology:

The assessment consisted of two key components, a facility level assessment and a community level assessment.

At facility level, structured clinical observations and interviews with staff, facility audits, records review and client exit interviews were conducted at the 12 target facilities in four districts of Morogoro. Observations included the ANC clinic, maternity ward, and postnatal ward services.

At community level, a series of focus group discussions were held with women who delivered within the last year, their male partners and community health volunteers. These focus groups were conducted in six communities in order to characterize community knowledge and perceptions of postnatal care, postpartum family planning, PMTCT and fertility return.

Results:

At facility level, compliance is good for counseling and testing of HIV during ANC; pregnant women are either tested in ANC ward or at the HIV Care and Treatment Center associated with the facility. Nevirapine is given to HIV-positive pregnant women at 28 weeks. However, there is a lack of follow-up with HIV-positive mothers and exposed infants after delivery. While providers appear to have some knowledge in areas of FP, ANC and PMTCT, understanding of contraceptive options for postpartum women, maternal pre-discharge counseling, and postnatal care is limited. Long acting contraceptive methods are only provided through mobile outreach activities limiting choice for many women. It is also noteworthy that while most women bring their babies to facilities for newborn immunization visits, the volume of postnatal visits is extremely low.

At community level, knowledge and use of postnatal care is found to be extremely low. HIV infection continues to convey stigma to those infected and while women undergo testing during antenatal care, few partners are tested. Exclusive breastfeeding is limited to one to three months although knowledge about continuing to exclusively breastfeed through six months is fairly high. It was widely perceived that HIV positive mothers should not breastfeed. There is considerable confusion regarding pregnancy risk. Although many couples do not practice traditional postpartum abstinence, there is a reluctance to acknowledge sexual activity and seek family planning services during the extended postpartum period. For those couples having long periods of postpartum abstinence, male partners are not expected to abstain, but have relations outside of marriage.

Lessons Learned:

The results of this baseline assessment confirmed the program strategy which aims to address existing gaps:
At the facility level, the program focuses on capacity building in 12 district hospitals and health centers where PMTCT, basic and comprehensive obstetric and newborn care is provided. In addition to existing PMTCT services, the integrated program ensures complementary efforts for maternity pre-discharge counseling, postnatal care, postpartum family planning and linkages with infant and under five immunization clinics and care and treatment services. Special efforts will be directed toward ensuring the provision of a range of contraceptive methods.

At community level, the program is working with existing community health workers to provide health information on PMTCT, focused antenatal care, malaria prevention, infant feeding, postnatal care, and postpartum family planning. A communications strategy around issues of postpartum abstinence and pregnancy risk is being developed.

The overall goal is to provide a continuum of comprehensive postpartum services, inclusive of FP and PMTCT for all postpartum women, including those who living HIV and their HIV-exposed infants, through an integrated facility/community approach.

F07: Service Delivery for Injectables, Implants, and Oral Contraception

Time: Tuesday, 17 November 2009: 2:00pm - 3:30pm

F07: 1
Assessment of Implant removal practices in Ethiopia: Early Assessment in Ethiopia

Tamrat Assefa1, Atle Bahiru1, Markus Steiner1, Heather Vahdat1, Altaye Kidane1, Tsegaye Asres2, Francesca Stuer2, Grethe Peterson2

1Family Health International/Ethiopia, Ethiopia; 2Family Guidance Association of Ethiopia; 3Family Health International, USA; 4Marie Stopes International, Ethiopia; TASsefa@fhi.org.et

Background/Significance
In the past several years, Ethiopia has greatly increased procurement of subdermal contraceptive implants. In 2006, for example, the country received 58,000 units; procurement increased to 237,000 and 406,000 units in 2007 and 2008, respectively. (2009 procurement levels are on track to surpass that of 2008). In 2008, Ethiopia received over half of all subdermal implants entering sub-Saharan Africa, through the generosity of three principal agencies: UNFPA, the World Bank, and USAID.

This rapid increase in procurement is nothing short of a contraceptive revolution. If the country continues at this pace and insertion levels match procurement levels, then by 2010 approximately 10% of Ethiopia’s 12 million married women of reproductive age will be using an implant. No other country in sub-Saharan Africa is remotely committed to level of rapid uptake for a single method. This projected level of contraceptive coverage will have tremendous demographic and reproductive health impact. The Ethiopian experiences can help other countries adopt the successes and avoid any pitfalls of this approach.

To absorb this level of procurement, the Ministry of Health has supported programs to train thousands of clinicians and make services available at their facilities. Numerous international agencies have helped in the training process. In addition, some private-sector, reproductive health agencies have provided services to meet the growing demand for contraceptive implants. There are no published removal rates or reasons for removals of implants in Ethiopia.

2. Main questions/hypotheses

The rapid procurement and uptake of implants raises many questions about how Ethiopian women are adapting to these changes. For example, are women using implants for short periods of time? Why do women have the implants removed prematurely? Family planning providers must also adapt to the changes. Do providers feel adequately trained? Are they encountering difficulties in removing implants? What recommendations do providers have to improve implant services? Are they getting the proper support they need to provide quality services? This study was designed to answer many of these questions.

3. Methodology (including location, setting, period, analysis approach)

This study was conducted at 15 clinics of the Family Guidance Association of Ethiopia (FGAE) and 14 clinics of Marie Stopes International/Ethiopia (MSI/E). From June 2008 to September 2008, research teams visited six different geographic areas of Ethiopia to collect data at the participating clinics. Interviews were conducted with implant users and implant providers.

a. Survey among women seeking implant removal

Over the study period, all women seeking implant removal were interviewed to collect information on sociodemographic information and reasons for removal. A structured questionnaire was used to record the answers.

b. Survey and focus group discussions among clinicians

At the participating clinics, family planning providers were asked about their experiences in implant removal services. Focus group discussions centered on attitudes/misperceptions of clients on implants, ways to improve services, and other topics.

4. Findings

A total of 619 women had their implant removed and were interviewed during the study period; 75% of the study population was 25 years of age or older and 54% had 3 or more previous pregnancies. Based on the average number of implants inserted during the reporting period, the proportion of early removal (≤ 6 months post-insertion) was 2%. The major reasons for removal included side effects such as menstrual disturbance (28%), desire for pregnancy (27%), and product expiration (25%).

Providers reported that over 70% of removals took 10 minutes or less to complete. In four percent of removal procedures, the implants were not in the expected location under the skin. In only two cases (out of 619) did the implants break upon removal.

From focus group discussions, providers stated that many clients still have incorrect information about the negative effects of using implants (loss of appetite, arthritis, etc). Providers shared their thoughts and concerns on mobile services (insertion camps) that are performed outside the clinic. Some providers thought that acceptors might not be getting thorough information on side effects and other contraceptive options before the insertion procedure. Also in the focus group discussions, providers thought that more effort could be made to educate community health workers on implants so women could get information locally before visiting a clinic. Finally, some providers mentioned that women seek removal services at their clinics because the service is not readily available at the location where the insertion took place.

5. Knowledge Contribution

This study of implant removal services at FGAE and MSI/E provides important information for the participating agencies as well as the Ethiopian Ministry of Health. First, the proportion of removals occurring in the first six months is similar to worldwide estimates; thus, it appears that early removal (an indication of inadequate counseling) is not a problem. Second, mobile services are critical to increasing access to contraceptive implants, but more effort is needed to train
local providers on how to counsel women and how to remove implants correctly and safely. As the implant program matures, more research is needed to evaluate services and provide feedback to providers.

**F07: 2**

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

Janet Wasiche⁴, Marsden Solomon⁵, Maureen Kuyoh⁶

¹Ministry of Health, Kenya, Kenya; ²Family Health International, Kenya; jwasiche2004@yahoo.com

1. Background

In the 1980’s and 1990’s, Kenya achieved significant strides in the family planning (FP) program. Contraceptive prevalence rate increased three fold from 7% (1978) to 39% (2003) and total fertility rate decreased from 8.1 children per woman to 4.9 during the same period. This success is partly attributed to a strong FP program including community based distribution and information, education and communication. However, these gains have been eroded by the large number of women and men getting into reproductive age; shift in donor and program focus to the HIV pandemic; and a deteriorating national economy affecting the health infrastructure. In the past year, there have been concerted efforts to reinvigorate the FP program in Kenya with the aim of meeting the high unmet need and continuing to realize the gains made in 1990’s. The World Health Organization has recommended task shifting as a viable approach to increasing access in provision of FP and other health services. This involves training and enabling lower cadre service providers to offer family planning services that hitherto were the prescribe of higher cadres of providers only. An example of a successful tasking shifting intervention in Kenya is the case of implants. Most FP providers in Kenya are nurses and limiting provision of implants to physicians resulted in limited access to the method.

2. Intervention

Contraceptive implants were introduced in the Kenya contraceptive method mix in 1989. However, its uptake was initially slow and by 2002 the program had about 50,000 sets of Norplant® procured through USAID funding that were about to expire. This situation raised an alarm within the MOH and its partners. To address this situation a task force under the leadership of MOH was formed to strategize on how to ensure the implants get inserted before their expiry date. Given that doctors providing implants were few, most clients who wanted implants had to book appointments on specific dates when the doctor would be available resulting in missed opportunities and possible unintended pregnancies. The task force determined that there was need to train nurses and clinical officers to insert and remove implants rather than restricting such services to doctors. Consequently, MOH issued a revision to the guidelines thereby allowing nurses and clinical officers to provide implants.

3. Methodology

A cascade approach to training and supervision was adopted to enable training and mentoring of more service providers. MOH also ensured that commodities and supplies were available at primary health facilities to facilitate provision of implants. With the repeal on the requirement that only doctors insert and remove implants, more providers were trained and more facilities at the lower level were able to provide implant services.

4. Outcomes

Within a period of about four months (March – June 2002) through cascade training, 400 nurses and clinical officers were trained in insertion and removal, increasing access to Norplant®. Within the same period about 40,000 Norplant® sets were inserted and the looming crises diverted. As more nurses and clinical officers are trained on implant insertion and removal, the demand for implants has since outstripped the supply and the MOH faces perennial implant stock-outs instead of expiry threats. The number of facilities offering implants has also increased from 72 in 1995 to 1200 in 2006.

5. Lessons learned

- Task shifting increases access to FP services and uptake.
- Training, supportive supervision and mentoring are critical elements of successful task shift.
- Central MOH commitment to task shift and galvanizing stakeholders support enhance the transfer of skills.
- Maximizing successes of task shifting to expand services requires attention to the supply chain to minimize stockouts.

**F07: 3**

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

Ndola Prata⁷, Amaneul Gesessew⁷, Alice Cartwright⁷, Martine Holston⁷, Deborah Karasek⁷, Malcolm Potts⁷

¹Bixby Center for Population, Health, and Development, University of California, Berkeley; ²Mekele University, College of Health Science, Mekele, Ethiopia; ³Venture Strategies for Health and Development, United States of America; mholston@venturestrategies.org

Background: According to the Ethiopian 2005 Demographic and Health Survey (DHS), 78% of married women say that they either want to delay the birth of their next child or to have no additional children. As only 14% of women are using a modern method of contraception, the unmet need for family planning is one of the highest in the world. Ethiopia has a limited distribution network of public or private providers in rural areas. Community-based distributors are only allowed to deliver oral contraceptives and condoms and are not permitted administer intramuscular injections of DMPA (Depot Medroxyprogesterone Acetate). While Health Extension Workers (HEWs) already provide DMPA in Ethiopia, Community Based Reproductive Health Agents (CBRHAs) currently are not permitted to administer injectable contraception, the preferred method of rural women in Ethiopia. DMPA is the fastest growing contraceptive method in the region, and there is a strong desire to use DMPA among rural Ethiopian women – a single dose offers long-term protection, it is female controlled and non-coital dependent. Limited access to health facilities that provide injectable contraception is a major cause of low contraceptive prevalence in Ethiopia, particularly in rural areas.

Intervention Tested: To generate evidence that CBRHAs can safely and effectively facilitate the supply of DMPA to rural Ethiopian women, a study comparing the provision of DMPA by HEWs and CBRHAs was conducted in Tigray, Ethiopia. In this study, women self-selected into different arms based on the type of provider they visit: CBRHA (intervention) or HEW (control). Working in conjunction with the Tigray Regional Health Bureau, we trained CBRHAs to deliver DMPA alongside pills and condoms in villages, and compared morbidity, client satisfaction, and continuation outcomes of intervention and control clients.

Methodology: We conducted surveys at enrollment (first injection), after three months (second injection), and six months after enrollment (third injection) to assess continuation and client satisfaction with the method and provider.

Results: The study aimed to recruit 1,000 women. Preliminary data from 976 women showed that more women self-selected into the intervention arm: 59% received DMPA from a CBRHA and 41% received it from a HEW. Both HEW and CBRHA clients are similar in age (29) and reported a low mean age at first marriage (16). While parity is high in both groups, CBRHA clients have a higher number of living children (6.9) than HEW clients (5.5). Educational attainment is
Addressing unmet need for family planning in Nigeria through a comprehensive package of services

Bridget Mary Adamou, Fatima Bunza, Abubakar Izge, Kemi Ayanda

Pathfinder International, United States of America; badamou@pathfind.org

1. Background/Significance:

As Africa’s largest nation with 133 million people, Nigeria’s fertility rate remains persistently high, at a national average of 5.2 children per woman. This is due mostly to deeply-rooted socio-cultural beliefs and norms, misinformed myths about family planning (FP) methods, and poor access to services - especially in rural areas.

According to the 2003 Nigeria DHS survey, a total of 13% of married women are using a method of FP, including 8% who are using a modern method. Of all women and men aged 15-49, 77% and 89.5% respectively knew at least one modern method of FP. However, only 0.2% of all women had been sterilized, 1.6% had used IUDs, and 0.1% had used implants. Only 0.2% of all men had been sterilized.

In relation to youth reproductive health (RH), nationwide 20% of girls were married by age 15, and 40% were married by age 18. Early marriage is very common in some regions and is often accompanied by early childbearing, where almost 50% of women nationwide and 70% of those in the northern regions give birth before age 20.

2. Program:

In response to the high fertility rate and unmet need for FP, the five-year USAID-funded COMPASS project focused on strengthening RH in four Nigerian states (Lagos, Nasarawa, Bauchi, and Kano) and the Federal Capital Territory (FCT). The project implemented a comprehensive set of health service interventions responsive to the needs of young people, men, women and families, focusing particular attention on hard-to-reach populations.

Through various levels of interventions, the project educated communities on the benefits of FP through the following interventions:

- involving community in the assessment, planning, implementation and evaluation of FP services and interventions;
- utilizing civil society organizations to get FP information, education, communication (IEC) and services to the grassroots level;
- promoting male involvement in FP services, including child spacing;
- involving religious leaders and faith-based organizations in overcoming misconceptions about FP services and disseminating information about child spacing;
- using community-based distribution (CBD) of non-prescription FP methods;

Once demand for FP was established, specific interventions at the facility level addressing access and quality included:

- infrastructure improvements;
- equipping and supplying facilities;
- training service providers on a variety of FP topics;
- reprinting and disseminating FP policy guidelines, standards of practice, and service protocols;
- providing IEC materials and a wide range of job aids;
- establishing 40 youth-friendly service (YFS) centers within health facilities;
- strengthening commodity logistics management systems;
- strengthening routine monitoring and supervision of FP service provision.

3. Methodology:

Shortly after the project launch in May 2004, COMPASS began collaborating with the FMoH and relevant SMoHs to advocate for improved FP access and services. Working closely with local governments and community-based groups, COMPASS identified and assessed project sites, ultimately supporting 712 health facilities, among which 51 select primary health centers became “model sites” which would benefit from more in-depth interventions.

COMPASS trained providers (including traditional birth attendants) in various FP methods and FP counseling and supported 3 teaching hospitals in training doctors and nurse/midwives on permanent and long term methods, specifically, implants and sterilization. COMPASS also trained a cadre of master YFS trainers in each state who could continuously provide stepped down training to lower level providers.
Local NGOs received sub-grants to conduct community outreach to increase demand for FP services. They met with community leaders and stakeholders to discuss the importance of FP, especially for youth, provided IEC information, and utilized their vast networks of CBDs to provide non-prescription methods. The NGOs were supported in reaching women in purdah and their husbands to educate them on the benefits of modern FP and child spacing.

FOMWAN, one of the COMPASS partners, was trained on child spacing and provided step-down trainings to their members to reach married Islamic youth. COMPASS worked consistently with SMoHs and the Deliver project to ensure a constant supply of FP commodities to the project-supported facilities.

4. Findings:
Contraceptive prevalence rates increased in the intervention states from 9% at baseline in 2005 to 32% in 2007 with the greatest jump occurring in Lagos, increasing from 14% to 40% in just 2 years.

5. Program Lessons Learned:
As the project neared completion in August, 2009, several lessons have emerged:
• With adolescents comprising about 50% of the Nigerian population, YFS are critical to meeting their needs and addressing a large part of the unmet need for FP.
• To access and win the trust of hard-to-reach populations, effectiveness increases when involving local civil society and faith-based organizations.
• Community leaders should be approached and educated about FP early on.
• Establishing community ownership of health challenges, such as unmet need for FP, promotes social change and sustainability.
• Significant shifts in FP use cannot be achieved by targeting women alone.

G07: Service Provision Assessments to Strengthen FP Programs
Time: Tuesday, 17 November 2009: 2:00pm - 3:30pm

G07: 1
Missed opportunities: Monitoring contraceptive supplies and stockouts
Paul Ametepi
Johns Hopkins Center for Communication Programs; Alfredo.fort@macrointernational.com

Background: Health facilities (both public and private) are a major source of supply of family planning methods in most countries. A facility that offers a wide variety of family planning methods, i.e., having a wide contraceptive mix, is best able to meet clients’ family planning needs; however, stock-outs of these family planning methods can contribute to discontinuation and unwillingness of clients to adopt any type of contraception.

Statement of problem/hypothesis: It is suspected that a key factor contributing to the discontinuation and unwillingness of clients to adopt family planning methods is the frequent non-availability of these methods at places where clients obtain them. The purpose of this paper is to describe and demonstrate that while a significant proportion of facilities in a number of developing countries report offering modern methods of family planning, stock outs are common and facilities offering these methods do not always have the said methods available to provide to clients.

Data and Methodology: We use facility inventory data from the 2006 Tanzania Service Provision Assessment (SPA) survey, the 2007 Uganda SPA, and the 2007 Rwanda SPA to examine the proportions of facilities that report offering specific methods of family planning, the frequency with which they offer the methods, and the proportions of facilities offering these methods that had the specific methods available in the facility on the day of the survey visit.

Findings: In general, between 71% (Rwanda) and 79% (Tanzania) of all facilities in the countries report offering some form of modern contraceptive method (i.e., they provide, prescribe or counsel clients on any of the following methods: combined or progestin-only pills, combined or progestin-only injectables, implants, intrauterine contraceptive devices (IUDs), male condoms, spermicides or diaphragms). In all these countries, government managed facilities are more likely to offer family planning methods than private facilities and facilities managed by other authorities. Between 65% (Rwanda) and 91% (Tanzania) of facilities offering these modern methods offer them 5 or more days per week. Facilities are more likely to offer combined oral contraceptives (Tanzania 94%, Uganda 91%, Rwanda 94%), progestin-only injectables (Tanzania 95%, Uganda 94%, Rwanda 93%), and male condoms (Tanzania 94%, Uganda 91%, Rwanda 91%) than other method. Of the 94% of facilities in Tanzania that reported offering combined oral contraceptives, only 85% had the method available in the facility on the day of the survey. In Uganda, only 79% of the 91% that reported offering combined oral contraceptives had the method available on the day of the of the survey, and in Rwanda, only 69% of the 94% had the method available in the facility on the day of the survey. Equipment and supplies essential for the provision of specific methods are often also not available. For example, in Uganda, only half of facilities that provide IUDs had all the equipment and supplies necessary for IUD insertion or removal.

Knowledge contribution: While a large majority of facilities in the three countries report offering modern methods of family planning and offer the methods to 5 or more days per week, quite a sizeable proportion do not always have the method available in the facility on all days (on the day of the survey), representing a missed opportunity to offer clients the method. Equipment and supplies necessary for the provision of some of these family planning methods are quite often not available in the facility. Since health facilities are a major source of supply of family planning methods, it is important that the methods are always available to provide to clients when they visit these facilities. Lack of methods or key items for their provision may affect contraceptive uptake or continuation, contributing to unintended pregnancies and even to stall in fertility.

G07: 2
Measuring quality of family planning services using Services Provision Assessment surveys
Rathavuth Hong¹, Alfredo Fort²
¹Demographic and Health Surveys at ICF Macro International, United States of America; ²Demographic and Health Surveys, PATH; Alfredo.fort@macrointernational.com

Background: Quality is one of the central issues in the provision of effective and acceptable healthcare services. Quality in healthcare delivery is loosely defined as providing the right services the right way. This means offering a range of services that are safe and effective, compliant with accepted standards of care and acceptable to clients. Supply and demand sides of care emphasize quality from difference but legitimate perspectives. Example, for clients, quality is the waiting time, privacy, information and services received, and interaction with the provider. The healthcare providers see quality as the outcome of services, competency, responsibility, and safety. The healthcare managers see quality as a result of services’ effectiveness and efficiency. Policy makers and
programmers view quality as the improvement in infrastructure, system, management; and the declining in morbidity and mortality and the increasing in services coverage rate. Thus, there is a need to integrate these definitions in a summary measurement, to represent areas of concern.

Statement of problem: There is no well-defined international gold standard for quality of care. The quality improvement standard of any given healthcare system is that --no matter how difficult the conditions and how scarce resources are-- every effort has to be made to achieve any improvements of the health services at a time. While there is a broad agreement in the international and national communities as to the importance of continuous quality improvement of healthcare, little accord exists regarding how to measure quality levels and quality improvement. A number of instruments have been developed to measure elements of quality of family planning services using the Services Provision Assessment (SPA) surveys developed by Measure DHS. SPA provides comprehensive information on several elements related to the quality of healthcare provision in family planning and other services, using nationally representative samples of health facilities. For each service, the survey instrument includes modules for inventory, observation, provider interview, and client exit interview. The objective of this study is to use SPA survey data to develop an index of quality for family planning (FP) and examine its difference by type of facility, managing authority, and geographic region in Egypt 2002, and 2004 surveys.

Data and method: 21 Items used to construct the index FP service were grouped into four components representing different clinical/managerial characteristics. Each component is given a component score (CS) of 25, assuming that each individual component is equally important. This score (25) is divided equally among items within each component. The total quality index (TQI) is the sum of values of the four components, which range between 0-100. The items had to be observed by the data collector; unobserved (but reported) items are considered not available. Some items are valid only if they are functioning properly, such tap water and spot light. For medicines, there must be at least one observed and unexpired unit. The Four components and 21 items are summarized as follow:

1. Counseling: (family planning guidelines, client privacy, visual aids for family planning, and individual client card.) Total score 25, item score 25/4.
2. Examination room: (client privacy, bed/table for examination, spotlight, speculum, soap, water, latex gloves, disinfecting solution, and sharp box.) Total score 25, item score 25/9.
3. Contraceptive supplies: (pills, injection, condoms, rhythm.) Total score 25, item score 25/6.
4. Management: (≥ 50% of provider received training in the last 12 months; ≥ 50% of providers were supervised in the last 6 months, family planning register up-to-date in the last 7 days.) Total score 25, item score 25/3.

Results: First analysis shows that TQI of FP in Egypt for 2002 is 75 (95% CI: 74, 76), and for 2003 is 72 (95% CI: 71, 73). The four CS are very similar ranging from 18 to 20 for 2002 survey and from 17 to19 for 2004 survey. While the score for contraceptives had not changed (18), scores for other component had decreased; from 19 to 18 for counseling, from 20 to 19 for examination room, and from 18 to 17 for management. There is considerable variation of the TQI of FP by type of facility, specifically in smaller facilities. In 2002 and 2004, the TQI of FP for hospital did not change (78), for maternity and urban health center were 78 and 79 respectively, for rural health center were 77 and 74 respectively, for health office and mobile unit were 76 and 73 respectively, and for NGO facility were 58 and 53 respectively.

Discussion and conclusions: On average the health care facilities are unlikely to change dramatically over a two-year period, and the similarity of the CS and the TQI between the two surveys was also expected. Even though there is a decline in TQI of FP from 2002 to 2004, the drop was small (3 percent). The drop is the result of decline in TQI among lower levels of health facilities. Based on initial finding this TQI of FP seems stable and it potentially can be used to measure trends of quality overtime, and to compare the quality between different types of facilities offering FP services across a number of countries, if components of the index are comparable.

GO:7 Common National and Subnational Flaws in Management Practices of Family Planning Services in Africa

Paul Kizito¹, Alfredo Fort²

¹National Advisory Council for Population and Development, Ministry of Planning, Kenya; ²Demographic and Health Surveys, PATH; Alfredo.fort@macointernational.com

1. Background/Significance

Fertility continues to be high in many low income countries, in particular in Africa. In some countries, despite initial fertility declines signaling the start of a fertility transition, levels have leveled off, potentially indicating a stall. Although explanations are complex, including effects from the HIV pandemic, the influence on use of contraception of family planning programs delivered with high standards of quality is well documented. Among the factors associated with strong family planning programs is an effective management strategy. We look at the situation of management practices for family planning programs in a number of West and East Africa countries where a facility survey has been conducted between 2002 and 2007.

2. Research: State main question/hypothesis

Program: State intervention/activity tested

This study compares the situation of management practices in 5 African countries, at national and subnational levels and then draws parallels with observed counseling practices during FP consultations.

3. Methodology (including location, setting, period, analysis approach)

We draw on data sets from Service Provision Assessments (SPA) done in 5 countries and dates: Ghana 2002, Kenya 2004, Tanzania 2006, Uganda 2007 and Rwanda 2007. We selected several measurements of effective management of family planning programs: Whether the facility has updated registers for FP (has an entry in the last 7 days, it is noted whether it is a first or follow-up consultations, and what was the service provided), Whether the provider was supervised in the last 6 months, Whether the provider received training in the last 12 months, and whether the facility has FP guidelines.

On the actual services provided, we selected common actions that have to be taken at the time of obtaining the client’s personal and medical history; Whether assessed current pregnancy status, Whether assessed current breastfeeding status, Regularity of menstrual periods, and Any Chronic Illness. For clients of hormonal methods, we included Whether the provider discussed potential side effects of the method.

Data were analyzed by type of facility (e.g., hospital, health center or post), management authority (e.g., Public, Private, NGO) and geographic distribution (e.g., regions or provinces).

4. Findings
All countries did relatively well in having updated client registers (from 70 to 90% of all facilities), though at subnational level there were a few contrasts, such as private facilities having the least registers, such as in Uganda (44%) and Rwanda (60%). Supervision also ranked high among countries (between 60 and 95%), however with marked differences such as only 35% of facilities in the Central Region, in Ghana, and lowest in lower level facilities such as Clinics in Kenya and Dispensaries/Posts in Rwanda. However, training gets the more disparity, ranging from only 5% of facilities in Tanzania having at least half of their providers trained in FP in the last 12 months, 16% in Uganda, to 53% in Ghana. With FP guidelines the situation is similar, ranging from 30% in Kenya, 40% in Rwanda, to 60% in Uganda and 70% in Ghana. Consequences of these management principles on quality of care also range widely, finding countries such as Rwanda which has high percentages of providers assessing key areas during client consultations, in contrast with much lower percentages (30-40%) of providers assessing pregnancy and breastfeeding in Tanzania and Kenya, and 30-40% of providers discussing side effects among hormonal contraception users in Ghana and Kenya.

5. Research: State knowledge contribution

Program: State lessons learned

Findings highlight the need for governments to invest in areas traditionally weaker within the health system, such as regular training for providers. However, of interest is to note that within a country there are areas that need strengthening, be them non public facilities, regions within the country or at times lower level facilities, which are supposed to overall cater for the large majority of the population.

Facility surveys provide indicators of readiness of a country to provide accessible and quality family planning services to its population. One cannot underestimate the need to strengthen health systems, together with improvements in socioeconomic conditions in order to improve health outcomes in the population.

G07: 4

Support systems for maintaining or improving family planning services in Africa

Gulnara Semenov1, Frederick Katumba1, Hamdy M. Abdel Ghaffar2, Mohamed Abdel Aziz Mostafa2, Fatma El-Zanaty3

1Demographic and Health Surveys at ICF Macro International, United States of America; 2El Zanaty and Associates, Egypt, Cairo, Egypt; 3Alfredo.fort@macrointernational.com

1. Background/Significance

In order to provide family planning (FP) services, adequate infrastructure and resources must be available to support quality counseling and examination of family planning clients. We look to what extent do support systems for maintaining or improving family planning services exist, and how well are they functioning in a number of West and East Africa countries and in Egypt, where facility surveys have been conducted between 2002 and 2007.

2. Research: State main question/hypothesis

Program: State intervention/activity tested

This study compares assessed infrastructure and resources that must be available to support quality counseling and examination of family planning clients in 5 African countries, at national levels and by facility type when possible, and then draws parallels with observed counseling practices during FP consultations.

3. Methodology (including location, setting, period, analysis approach)

We draw on data sets from Service Provision Assessments (SPA) done in 5 countries and dates: Ghana 2002, Egypt 2004, Kenya 2004, Tanzania 2006, and Uganda 2007. The following infrastructure and resources for providing quality family planning services were assessed: equipment for client examinations, written service guidelines and protocols, trained staff, a service delivery setting that allows client privacy, supplies and procedures for preventing infections, individual client health cards or records, and visual aids.

Data were analyzed by type of facility (e.g., hospital, health center or post), management authority (e.g., Public, Private, NGO) and geographic distribution (e.g., regions or provinces).

4. Findings

All conditions for quality counselling (visual and auditory privacy, individual client health cards, written protocols, and visual aids) were met by 51 percent of all facilities in each Tanzania and Ghana, 34 percent in Uganda, 29 percent in Egypt, and 22 percent in Kenya. Written protocols or guidelines for family planning were the items most commonly missing in all countries, except Uganda, where individual client’s cards were the most missing item. In general, all conditions for counselling were more often available at hospitals than other health facilities.

Supply of infection control items, such as soap, sharps boxes, latex gloves, disinfectant and water varied from country to country, being disinfecting solution the most often missing item in Uganda, Kenya and Ghana, while latex gloves were mostly missing in Egypt, and regular water supply was missing in Tanzania. Less than 20 percent of facilities offering FP services in Egypt and Ghana had all infection control (IC) items, while Kenya was the best supplied (41 percent of facilities with all IC items).

Private rooms and beds to conduct a physical examination are available in the vast majority of the facilities in all countries. However, when all furnishings and equipment necessary for pelvic examinations are assessed together (room with visual and auditory privacy, examination bed, examination light, and vaginal speculum) percentages drop markedly to only 15 percent of facilities in Ghana, and down to 8, 3, and just 1 percent in Kenya, Tanzania, Uganda, respectively, compared to 70 percent in Egypt (the most absent item is a spotlight source for visualizing the cervix). Other key items are often found missing, such as a vaginal speculum.

When looking at the basic equipment to offer specific FP methods, the same lack of availability of minimal conditions is found. In Egypt, for example, among those facilities offering IUDs, only 23 percent have the basic equipment necessary for insertion (latex gloves, antiseptic solution, sponge forceps, speculum, tenacula, uterine sound), compared with over half of those facilities in Uganda, Kenya and Ghana.

5. Research: State knowledge contribution

Program: State lessons learned

Basic infrastructure to provide family planning service is strong in all countries. However, capacity of facilities to provide quality family planning services varies greatly from country to country and is generally weak mainly because of the low percentage of facilities that have important items such as an examination light, a speculum, disinfecting solution, and water. Often a single missing item can compromise overall capacity to provide quality services. Also, capacity to provide quality family planning services can be easily improved through sustainable provision of missing items, probably seen as trivial, such FP service guidelines and individual client cards.
P4: Poster Session 4: Contraceptive Technology, Financing and Reproductive Health Issues

Time: Tuesday, 17 November 2009: 3:30pm - 4:00pm

P4: 1

Pattern of Contraceptive Use Among Women with Sickle Cell Disease in Ibadan, South - West Nigeria.

Michael Abiola Okunlola, Adebowale Abimbola Oluwayo, Titi Akingbola, Stella- Maris Ngozi Okonkwo, Akinlade Olawumi Adeleke

University College Hospital, Ibadan, Nigeria; templecity108@yahoo.com

Background

Women with haemoglobinopathy are a particular group of people who need to limit their family size and require contraception to do this. The purpose of this study was to determine the pattern of contraceptive use among females of reproductive age group with sickle cell disease attending various clinics at the University College Hospital, Ibadan, Nigeria.

Hypothesis: Nil

Methodology

A cross sectional study was conducted at the University College Hospital Ibadan, Nigeria between January and April 2009. A total of 408 questionnaires were administered but 307 were analyzed giving a recovery rate of 75.3%..

Findings: The modal age group was 21 – 25 (40%). 66.7% were single. Most of the patients were hemoglobin genotype homozygous S (53.3%), 6.7% were not sure of their genotype and the rest were SC. Only 47 patients had ever used contraception giving a prevalence of 15.3%. Up to 90% were aware of one form of contraception or the other and contraception was acceptable to 70.1% of them especially to prevent unwanted pregnancy. About 62% of the respondents had a good knowledge of contraception and 5% had ever used emergency contraception. Only 10% had ever used male condom, 6.7% injectables, 4.4% oral contraceptive pills, 5% had used intrauterine contraceptive device (CuT) and 1 person (0.3%) had bilateral tubal ligation. 16.7% experienced one form of side effect or the other ranging from reduced menstrual flow, irregular menstruation, abdominal pain and headache. 18.3% had unwanted pregnancies which were voluntarily terminated.

Lessons Learned: It is evident in this study that even though contraceptive awareness in this group of patients is high, the prevalence of contraceptive use is very low which is comparable to what obtains in the general population. This is largely due to perceived fear of real and imagined side effects associated with some contraceptive methods and also relative lack of access to commodity sources. It is therefore suggested that there is need for effective enlightenment and health education targeted at this vulnerable group of women to disabuse their minds about those unreal fears about contraception, as these are women who can hardly withstand the problems of unwanted pregnancies and abortion complications. Also the provision of a contraceptive friendly environment especially at various clinics attended by sickle cell disease patients to facilitate their access to contraceptive commodities will go a long way to enhance their uptake of contraception while preventing unwanted pregnancies along with other benefits in this susceptible group of women. The need for child spacing as well as limiting family size among sickle cell disease patients can not be over emphasized.

P4: 2

Determinants of home deliveries in Tanzania: Analysis from the 2004 Tanzanian Standard Demographic and Health Survey

Bellington Wwalika

University Teaching Hospital, Lusaka, Zambia; bellingtonwwalika@rzhrg.org

Background

Exposures to family planning messages and husband approval of family planning have been shown to all exert an influence on a woman’s decision to seek care during labor. The role of the actual use of a modern contraceptive method by these women in this decision has largely been ignored. Research in sub-Saharan Africa has typically concentrated on the use of any contraceptive method rather than the use of modern methods or any examination of areal (sub-national) variations in contraceptive use. This is probably because modern contraceptive use has typically been very low and increasing uptake has only occurred recently. This study examined the association of ever use of modern contraceptive with the decision about the place of delivery of the baby, extending upon previous studies by including the role of better known determinants for place of delivery such as education, age and parity in the analysis.

Hypothesis

According to the 2004 TDHS 47% of deliveries occurred at the health centre and 53% at home. This is despite of the known risks of home deliveries. There was a similar finding in the 1999 TDHS. There has been a steep increase in the number of women using a modern method of contraception in Tanzania. People who use modern contraceptive are conscious about the number of children they need to have and are likely to have received information on the need to deliver at the health institution. It can be hypothesized that these people are likely to deliver at the health institutions.

Methods

Analysis of the 2004-2005 Tanzania Demographic and Health Survey (TDHS) was conducted to study the association between ever use of modern contraceptive method and choice of place of delivery. Place of delivery was determined for 5656 mothers who delivered at a health facility and at home (3017 and 2639, respectively). Multiple logistic regressions was performed to adjust for confounders related to ever use of modern contraceptive and choice of place of delivery. Results

Overall women who used a modern contraceptive method were more likely to deliver at a health facility than those who did not (OR 2.682, 95% CI 2.111-3.400). This remained significant after adjusting for the confounding effect of maternal age, parity, education and place of residence (OR 2.037, 95% CI 1.64-2.553).

Lessons Learned

Use of a modern method of contraception is independently associated with the choice of a place of delivery. High parity has a negative association with delivery at health facility and so are increased maternal age, reduction in education and decreased number of antenatal visits. The time when women are seeking modern methods of contraception provide a opportune time for educating them about the importance of delivering at the health institutions when they decide to get pregnant.
Comparative Pharmacokinetics of Depo-Provera (Depo-Medroxy Progesterone Acetate) and generic DMPA manufactured in Pakistan

Badruitdin Abbasi
Ministry of Population Welfare, Government of Pakistan, Pakistan; badarcmc@hotmail.com

Background

1) Different brands of DMPA is being used by Ministry of Health, Ministry of Population Welfare Program, social Marketing programmes and Non Governmental organizations. With the increase in acceptance of injectable contraceptive, unmet need and the growing logistic problems with imported brands, Future Group UK provided a support to strengthen local Pharmaceutical firm in Pakistan to manufacture DMPA in Pakistan and provide cheap yet effective injectable contraceptive as per demand minimizing the logistic problems like issues of caking, storage and supply.

2) Hypothesis or Intervention/Activity Tested

To compare pharmacokinetics of both products in the blood serum of 80 women to ensure the effectiveness. Strengthen capacity of the local pharmaceutical company to produce effective yet affordable contraceptive.

3) Methodology

This comparative study of two Depo-Provera with Generic was carried at four research clinics providing Family planning services in Karachi Pakistan.

The study was approved by scientific and Ethics Review Committee. Eighty fertile women were recruited at those clinics, 40 for each injectable and 20 at each Clinic, after recording informed consent. Women between the ages of 15-40 years of proven fertility with regular menstrual cycles and no history of hormonal contraceptives use during last three years, were recruited for the study.

20 blood samples were collected from each participant and analyzed.

Statistical Analysis

Due to the randomization at clinic level, the study had a clustered design. Baseline data are summarized as mean and standard deviation. t-tests adjusted for the cluster effects used for analyzing differences in continuous outcomes. A p-value < 0.05 (two-sided) considered statistically significant.

4) Finding

Blood samples collected from 80 women during 20 visits analyzed and found progesterone level slightly but non-significant among women who received the locally manufactured DMPA group B as compared to those who received Depo Provera group A. At first visit, progesterone value in group who received Generic DMPA was 1.87ng/ml (SD=3.614) where it was 1.47ng/ml (SD=4.22) in group received Depo-Provera.

Average values in both groups steadily declined on successive visits over all the pattern remained identical in the two groups.

5) Knowledge Contribution or Lessons Learned

Results demonstrated the confidence to introductive locally manufactured DMPA injectable in Pakistan. Strength of this study was no loss to follow up and the weakness was that the study was to study effectiveness where as it would have been more useful if sponsors have studied those cases in follow up for at least one year.

Risk perception limits use of modern contraception in Ga East District, Ghana

Richmond N. O. Areyetey, Agnes N. Kotoh

School Of Public Health, University of Ghana, Ghana; mokai@yahoo.co.uk

Background/Significance

The 2009 world health statistics ranked Ghana third among African countries with the highest unmet need (34%) for Family planning (FP). A preliminary report of the 2008 Demographic and Health Survey indicates a decline in the use of modern contraception in the last 5 years. In year 2007, the School of Public health in Ghana was invited to investigate high rates of adolescent pregnancy and low coverage of FP services in the Ga East district of Ghana.

Study objective/Rationale

One of the objectives of the study was to identify factors that determine current use of modern FP methods in the Ga East district. The study was intended to serve as a basis for improving community-based family planning service delivery.

Methodology

In a cross-sectional study, 475 eligible community members (both male and female) aged at least 15 years were selected, using a convenient household sampling approach, to complete a structured questionnaire. A target of 120 respondents was planned for inclusion in the study from each sub-district. Field interviewers visited homes in the four main towns in the district (Danfa, Taifa, Akobbi and Dome) to invite eligible residents to participate in the study. Interviews were administered face-to-face by trained research assistants. Within each household, all eligible members were invited to participate, voluntarily, in the study. In addition to summary statistics and descriptive analysis, logistic regression models was used to identify independent determinants of modern FP use.

Findings

A majority of respondents were living in peri-urban communities (75%), female (70%), of Christian religion (92%), and aged between 20 and 49 years (88%). Akan (49%), Ewe (24%), and Ga-Dangme (18%) were the main ethnic groups represented in the survey. Almost every participant (97%) had heard about FP. While 60% of respondents had previously used a modern FP method, only half of these were currently using any modern method at the time of the study (i.e. 31% of the total sample). Among current users, male condoms (51%) and injectables (24%) were more commonly reported. About 80% of current users were aged between 20 and 39 years and were mainly Christians (93%). About 60% of current users were not married and three-quarters of users were living in peri-urban communities. Males (OR=1.05; p=0.01), age groups 20-29 years (OR=2.98; p=0.18), and 30-39 years (OR=3.00; p=0.02), were more likely to report current use of a modern FP method, while those who perceived contraceptives as unsafe (p=0.01) were less likely to be currently using them. Only a minority of respondents indicated cost (11%), inadequate privacy (17%), and delay during service provision (11%) as limitation to their use of modern FP. Use of modern FP methods was more likely among respondents who indicated that the decision to use FP should be made jointly by both partners, although this relationship was not statistically significant (OR=1.99; p=0.09). In a multivariate model that controlled for age, location, and education, male gender (p<0.01) and perception of contraception risks (p<0.01) were the only predictors of current use of modern contraceptives.

Conclusions/Recommendation
The current analysis indicates poor usage of modern FP in the Ga East district among both rural and peri-urban residents. This poor level of modern FP usage is not unique to the Ga east district. In 2007, the Ghana Maternal Health Survey reported that only 14% of 15-49 year old women were currently using modern contraceptives. Irrespective of location, perception of risk is limited by the use of modern FP, especially female methods. The evidence does not support a FP service provider barrier. To improve use of modern FP in the Ga East district, it is recommended that FP service provision must address inaccurate risk perception at the community level, and should particularly, target women of reproductive age, using an appropriate community education intervention.

P4: 5

Effect of Gender Composition of Surviving Children on Contraceptive Use and Method Choice in Bangladesh

S. M. Mostafa Kamal
Islamic University, Kushthia-7003, Bangladesh; kamaliubd@yahoo.com

1. Background/Significance
Son preference over daughter is a well-known phenomenon in the South, East, West Asia and North African countries. The low status of women and a strong preference for a male child are two patriarchal constraints in these countries. The inferior status of women and the consequential preference for son has contributed to a widening range of gender inequalities in Bangladesh. In recent decades the country has made remarkable progress in health sector and gender development indicators, but still far away to reach at replacement level of fertility; suggests the need to understand the effect of sex preference on contraceptive use and method choice.

2. Hypothesis or Intervention/Activity Tested
The study aims to investigate the effect of sex composition of surviving children on contraceptive use and method choice among currently married women in Bangladesh. It has been hypothesized that the use and choice of contraceptive method varies significantly among subgroups of women by socioeconomic, demographic and programmatic factors.

3. Methodology
The study dealt with nationally representative weighted sample of 9099 currently married women with at least one living child by extracting data from 2007 Bangladesh Demographic and Health Survey (BDHS). The data collection took place over five months from March to August 2007. Both quantitative and qualitative statistics have been used to examine the association and effects of sex preference along with various socioeconomic factors on contraceptive use and method choice. To investigate the effect of sex composition of surviving children along with other socio-demographic factors on current contraceptive use we applied binary logistic regression analysis, while multivariate multinomial logistic regression analysis was employed to estimate the risk of traditional and modern method choice. The results have been presented by odds ratio (OR) with 95% Confidence Interval (CI). All of the statistical analyses have been performed by SPSS 11.5 software.

4. Data (if relevant)
The study used data from the latest 2007 BDHS. The 2007 BDHS is a nationally representative survey of 10996 ever married women of reproductive age and 3771 men of age 15-54. The survey obtained detailed information on fertility, marriage, awareness and use of family planning methods, nutritional status, knowledge and attitude regarding HIV/AIDS etc. Such a large data set provides a unique opportunity to study the contraceptive use and method choice in relation with sex composition of surviving children among married women of Bangladesh.

5. Findings
Overall, the contraceptive prevalence rate in Bangladesh was 55.8% in 2007, included modern method 47.5%. The use rate of any contraceptive method among women with at least one living child was found 60.2% and modern method use rate was 51.4%. The most preferred modern methods were pill, injections, female sterilization and condom; and traditional method was periodic abstinence. The findings reveal strong son preference over daughter among Bangladeshi women. For instance, the both bivariate and multivariate analyses showed significantly (p<0.001) higher use rate of contraceptive methods among women who had son(s) than women who had only daughter(s). The multivariate binary logistic regression analysis yielded significantly (p<0.001) decreased risk of any contraceptive use (OR=0.69, CI=0.60, 0.79) among women who had only daughter(s) compared to those who had had both son(s) and daughter(s). The results of multivariate multinomial logistic regression analysis further confirms significantly (p<0.001) lower risk of traditional (OR=0.65, CI=0.50, 0.83) and modern method (OR=0.68; CI=0.58, 0.78) use among women who had only daughter(s) than those who had both son(s) and daughter(s). There was not found significant variation in contraceptive use and method choice among women who had only son(s) and who had both son(s) and daughter(s). Among other variables included in the analysis place of residence, religion, working status, NGO membership, visitations of family planning workers, mass media exposure, child mortality and region were found to have significant (p<0.001) effect on use and contraceptive method choice net of other socioeconomic factors. Although preference of traditional method was significantly higher among women with at least secondary education, the categories of maternal education appeared to be insignificant for modern method preference.

6. Knowledge contribution or Lessons Learned
Strong son preference over daughter is still deeply embedded in Bangladeshi culture. Home visitations, NGO membership and mass media exposure are the most important determinants of contraceptive use and method choice in Bangladeshi women. Family planning fieldworkers should make greater efforts to extend their services. The NGO can play vital role in motivating their clients to adopt modern contraceptive methods. Special programs should be undertaken through additional information, Education and Communication (IEC) to inspire husband’s participation in family planning program. Door-step delivery services of modern contraceptive methods should be ensured to each and every corner of the country for extra cutback of TFR in Bangladesh to reach at replacement level.

P4: 6

Awareness and Use of Family Planning Services Among Mothers’ Group

Tej Bahadur Karki
Nepal Red Cross Society, National Headquarters, Kathmandu, Nepal; nawraj.karki@gmail.com

Background:
The specific objective of this study is; “To find out the level of awareness and practices of family planning services among the mothers’ groups in Nepal.” To conduct this research, one community of Udayapur District was taken as sample study area. The district has 288152 population including 46 VDCs and 1 Municipality.
The main trust of the National Health Policy of Nepal (1991) in relating to the National Family Planning Program is to expand and sustain adequate quality family planning services to communities through all health facilities. Female Community Health Volunteers (FCHVs) are to be mobilized to promote condom distributions and re-supply of oral pills. Awareness on family planning (FP) is to be increased through various IEC/BCC interventions as well as active involvements of FCHVs and Mothers (DoHSS Annual Report 2063/64).

The Government of Nepal initially introduced contraceptive method mainly with the objective of reducing birth rate but later this was emphasized not only to reduce birth rate but also to reduce infant and child mortality and maternal morbidity and mortality.

The efforts made by the government, NGOs, and the private sector in trying to improve the RH situation have paid off well. Contraceptive prevalence rate has risen from 3 percent in 1976 to 48 percent by 2006. Total fertility rate showed an unpreceded decline of one child per woman in five years (TFR declined from 4.1 in 2001 to 3.1 in 2006). Maternal Mortality Ratio (MMR) has declined remarkably in the last ten year from 539 per 100,000 live births in 1996 to 281 in 2006. The proportion of married adolescents beginning childbearing declined from 21 percent in 2001 to 19 percent in 2006 (MOHP, New ERA and Macro International Inc, 2007).

The women with unmet needs for contraceptive method services are always at high risk of unwanted pregnancy and other women who never expressed any desire for contraception (27 percent) are also equally at high risk of unwanted pregnancy which ultimately leads to unsafe abortion.

Methods:

To conduct this research, researcher had used the simple random sampling method. Approximately there were 135 members of Mothers’ Groups in which 50% was taken as a sample size for research. The complete research was conducted as a blend of qualitative as well as quantitative approaches including exploratory and descriptive research designs. Questionnaires, Key Informant Interview (KII) and Focus Group Discussion (FGD) techniques were used to collect the primary data.

Result:

The research shows that the respondents of the study area had good and sound knowledge about the use of family planning services, and most of them were self-users also. Without any hesitation they can explore their knowledge among the communities’ people. More than 80% had good access on service.

During the time of study, from the conclusion of FGD, KII and personal observation of researcher has found that there are various factors that hinder the awareness about family planning methods, HIV & AIDS or reproductive health among the women; such as educational status, socio-economic status, family background, culture, religion, and users' psychology; like fear of death, side effect. Similarly superstitious believe; like “without son nobody can go heaven after death,” and somewhere, religious norms.

Findings:

- The respondents were generally 20 to 45 years' group and data collected from all communities.
- On the test of knowledge about family planning methods; 100% had knowledge of Family planning.
- 32.86% participants had got information from Radio, 5.71% from Television, 2.85% from family, 44.29% from friends and 14.29% from books. It shows that majority of respondents has got information from friends and very less numbers of participants have got from the family.
- Similarly, in the case of openness or capacity of open discussion among the mass groups, 81.43% can openly talk about the FP methods and only 18.57% said that they can't talk openly among their relative and family members.
- Out of 70 participants, 75.86% are self-user (female) and 24.14% are male users.
- The female users were asked about the types of contraceptives; the finding is as below: out of 44 females user; 9 or 20.45% are using pills, 1 or 2.28% using Norplant, 27 or 61.36% using Depo and 7 or 15.91% have already used the permanent method. During the research, Copper-T users were not found.

Conclusion:

Nepal is classified as a developing country; its majority population is covered by women. The research was carried out with the blend of qualitative & quantitative data. The findings of research show that 100% participants have good knowledge and more than 75% females were self user. Some extraneous variables that hinder the family planning service in communities.

By: Tej Bahadur Karki

P4: 7

UFAC: Scaling up Female Condom Use!

Ilze Roza Smitt1, Lucie van Mens2, Victoria Archibong3, Annie Michèle SALLA4

1World Population Foundation, Netherlands, The; 2Universal Access to Female Condoms Joint Programme; 3Society for Family; 4Association Camerounaise pour le Marketing Social; l.Smit@wpf.org

1. Background / Significance

Throughout the world, there is an unmet need for family-planning contraceptives and methods to prevent STIs and HIV. Women especially bear the negative consequences of this unmet need. Around 200 million women worldwide have no access to contraceptives. One third of all the pregnancies are unintended and mostly unwanted. Female condom use could significantly reduce the number of unwanted pregnancies and STI’s. Studies show high acceptability of female condoms but, till now, no efforts are made to scale up the use of female condoms. Small programs are carried out with focus on HIV prevention towards specific target groups like sex workers.

The Universal Access to Female Condom (UFAC) Joint Program aims at making the female condom available, accessible and affordable for all. The ultimate goals of the program are to reduce the number of unwanted pregnancies and to reduce the incidence of new cases of STIs and HIV-infection. It is obvious that product unavailability coupled with its relatively high price and poor awareness among the general public have contributed to maintain the female condom demand at an insufficient level.

2. Intervention / Activities

Within the framework of the Universal Access to Female Condom (UFAC) Joint Program, two large scale country projects for female condom are being implemented. In Nigeria almost 4 million female condoms will be distributed in three years; for Cameroon that is 3 million female condoms. The programs consist of scaling up the social marketing activities. This implies improving product supply, boosting its demand and fostering market competition around the female condom. The programs also consist of empowering women through interpersonal communication, in taking the ownership of Female Condom both as a
Family planning and STIs prevention tool. As a result, the retail unit price is expected to decrease making the product more accessible than before. The programs encourage the public acceptance of the female condom as a commodity that enables women to exercise their sexual and reproductive rights.

All these factors will be addressed through a combination of four types of activities:

a) Demand creation.

b) Supply chain management.

c) Female condom inclusion in existing programs and health services.

d) Product development and quality control.

In Nigeria, UAFC Joint Program works with Society for Family Health (SFH) and, in Cameroun, with the Association Camerounaise pour le Marketing Social (ACMS).

3. Methodology

A wide range of strategies and methods are used in the countries. Complementarity between the public health sector, private sector and civil society, introduction of various types of female condoms, integration and mobilization of a broad range of youth and women’s groups and advocacy are key to success. The UAFC Joint Program started in January 2009 and will end at December 2011.

Lagos, Delta and Edo state in Nigeria:

Key activities include:

Increasing awareness of female condoms through integration with RH programs:

- Stakeholders meeting at all levels with community leaders and activists to sensitize them on female condom.

- Peer education and community outreach programs.

- Distribution of educative materials through local NGO and CBOs.

- Giving strong mass media and promotional support to female condom programs.

- Increasing knowledge on female condoms by integrating female condoms into existing behavior change communication activities.

Increasing access to female condoms through:

- Social marketing based on existing distribution.

- Subsidize product to enhance uptake.

- Regular supply and re-supply of products by the sales team.

- Interpersonal communication activities.

Urban and semi-urban areas in Cameroun:

The intervention follows a logical framework and progressive development based on evidence. The project starts with a situation analysis and a needs assessment of the target groups through CAP and MAP studies carried out by independent research agencies. The analysis of the results helps to determine the strategies, the approaches, but also to adapt the messages to the needs of the target groups. IEC tools and messages are systematically pretested among the target groups.

The third stage is the implementation of the intervention after validation of the IEC messages.

Monitoring and evaluation of the project through joint supervisions, meetings of the Steering committee and field reports and studies mark the last major action in the implementation.

4. Data and Finding: not yet available but will be available at the Conference. The launch of the programmes will be in Nigeria at the 30th of June and in Cameroun in October. Findings on the first stages of the programmes (developing IEC materials, fill the supply pipe-line and involving all actors) will be shared at the conference.

5. Lessons learned

- Availability of the product, lower price and public awareness are prerequisites for the success of female condom programming.

- Not focusing on one target group (such as sex-workers) and involving men as target group from the beginning of the program are key to acceptance of the product.

- Female condom has to be positioned as a contraceptive alternative rather than a HIV prevention method. The association of the product with HIV stigmatizes both the product and the user.

See for more information: www.condoms4all.org

P4: 8

New estimates on unintended pregnancy in sub-Saharan Africa and potential role of contraceptive implants to alleviate the problem

David Hubacher1, Ifigenia Mavranzeouli2, Erin McGinn3

1Family Health International, United States of America; 2University College London; 3EngenderHealth; dhubacher@fhi.org

1. Background/Significance

All throughout sub-Saharan Africa, millions of women would like to avoid pregnancy. In surveys conducted since year 2000 in 29 sub-Saharan African countries, about one-quarter of reproductive-aged women state they do not want any more children and about one-third want to wait at least 2 years before having a child. In these same surveys, nearly 90% have knowledge of at least one form of modern birth control yet only one-third have ever used one. Moreover, when asked about the planning status of their last birth, between 10% and 65% of women report the event was unintended, depending on the country and age group of the respondent.

Many unintended pregnancies occur from incorrect or inconsistent use of modern forms of contraception; in addition, a decision to temporarily stop using a method may result in unintended pregnancy at a later time. For a host of different reasons, short-term hormonal methods such as oral contraceptives and
injectables are susceptible to early discontinuation. In contrast, long-acting reversible methods, such as subdermal implants, have low discontinuation rates, but are sometimes difficult to get.

2. Hypothesis

Our aim was to estimate the number of unintended pregnancies in sub-Saharan Africa and model the impact of expanding use of contraceptive implants at the expense of short-term hormonal birth control methods. Given existing data sources, we hypothesized that a significant number of unintended pregnancies could be averted if more women voluntarily used implants instead of short-term hormonal methods.

3. Methodology

We used a decision-analytic model to estimate the number of unintended pregnancies that could be averted if women in sub-Saharan Africa had a better opportunity to choose and use an implant instead of short-term hormonal methods. First we estimated the number of unintended pregnancies per 1000 women associated with use (and some subsequent disuse) of injectables, oral contraceptives, and contraceptive implants over a period of 5 years. We assumed that each cohort of women would begin using one of the birth control methods with intentions to avoid pregnancy over a 5-year period. Then, in the simulation, we subjected each cohort to method-specific discontinuation rates and then assumed a proportion would adopt a new method of contraception. We used region-specific estimates of discontinuation rates, as provided by DHS. In each step of the modeling process, we made assumptions that would provide a conservative measure of the potential impact.

After estimating the number of unintended pregnancies per 1000 women associated with use of injectables, oral contraceptives, and contraceptive implants over a period of 5 years, we calculated the number of unintended pregnancies that could be averted if varying percentages of the millions of injectable and oral contraceptive users in sub-Saharan Africa used the contraceptive implant instead, at the start of the 5-year period.

We performed a sensitivity analysis to explore the robustness of the results, by modifying method discontinuation rates and the proportions adopting another contraceptive.

4. Data

To estimate the magnitude of the problem of unintended pregnancy in the 42 mainland countries of sub-Saharan Africa, we used information on births from the United Nations Secretariat, estimates on unintended pregnancy from the Demographic and Health Surveys (DHS), and estimates of abortion rates in the region. To estimate the total number of women using oral contraceptives, injectables and other forms of birth control in sub-Saharan Africa we used the DHS and other national surveys conducted since year 2000. Since the original publication [1], seven new DHS datasets from sub-Saharan Africa have become available.

5. Findings

Every year in sub-Saharan Africa, approximately 15 million unintended pregnancies occur and a sizeable proportion is due to poor use of short-term hormonal methods. As expected, younger age groups contribute disproportionately to this total, given higher fertility rates; women under age 25 bear 44% of the total estimated number of unintended births in the region. Short-term hormonal methods are the most commonly used form of modern birth control in the region. If 20% of the 17 million women using oral contraceptives or injectables wanted long-term protection and switched to the contraceptive implant, approximately 2 million unintended pregnancies could be averted over a 5-year period.

6. Knowledge Contribution

Poor patterns of short-term hormonal contraceptive use (high discontinuation rates and incorrect use) contribute significantly to the problem of unintended pregnancy in sub-Saharan Africa. Women using short-term hormonal methods are the easiest group to reach and the group with the highest potential to be interested in switching to contraceptive implants. With growing interest in implants in sub-Saharan Africa, any intervention aimed at increasing uptake of implants will have immediate impact. More availability and widespread use of highly effective methods, such as the contraceptive implant, will improve reproductive health in the region.


P6: 9

Les motifs d’adhésion des hommes à la planification familiale au Bénin

Ayédélé Amour Balogoun, Blaou Guy Franch Ale

Population Services International (PSI), Benin; abalogoun@psibenin.org

1. Contexte:

Entre mai et juillet 2008, PSI-Bénin a initié une étude sur les déterminants de l’utilisation des méthodes modernes de contraception au Bénin. Cette étude s’est déroulée dans sept communes du Bénin. La population cible est constituée des hommes époux ou partenaires de femmes de 15-49 ans.

Au Bénin, des études ont montré que l’un des déterminants prédominants de l’utilisation des méthodes modernes de contraception par les femmes est le soutien de leur partenaire.

2. Recherche :

Quel est le profil des hommes qui soutiennent leurs épouses à la pratique de la planification familiale?

Programme :

PSI-Bénin oeuvre à la croissance de la prévalence de l’utilisation des méthodes modernes de contraception. Les résultats de cette étude vont permettre de développer les stratégies adaptées pour motiver le soutien des hommes à la planification familiale.

3. Méthodologie :

Cette étude a porté sur un échantillon de 584 hommes époux ou partenaires de femmes de 15-49 ans. Les répondants ont été identifiés dans des ménages à l’aide des données du recensement général de la population 2002 suivant un sondage aréolaire stratifié à trois degrés. Les entretiens se sont déroulés à l’aide d’un questionnaire individuel pré codé. Les données ont été analysées avec le modèle de régression logistique général en utilisant le logiciel SPSS.

4. Données

Il ressort de cette étude que les hommes ayant une bonne connaissance des méthodes modernes de contraception (p<0,05 , OR=1,0) sont enclins à soutenir leurs partenaires à l’utilisation de la planification familiale. L’élément le plus déterminant (p<0,001 , OR=3,0) du soutien des hommes aux femmes à l’adoption
Impact of the integration of Lactational Amenorrhea Method within a community based maternal, neonatal and child health program

Salahuddin Ahmed,1 Rusheduzzaman Shah,2 Ishtiaq Mannan,3 Angela Nash-Mercado1, Emma Williams2, Peter Winch3, Saifuddin Ahmed4, Ahmed Al-Kabir4,
Catharine McKaig5, Abdullah Baqui2

1Johns Hopkins Bloomberg School of Public Health, Bangladesh; 2Johns Hopkins Bloomberg School of Public Health, Baltimore, MD; 3ACCESS-FP of Jhpiego; 4RTM International, Bangladesh; sahmed773@yahoo.com

Background/Significance
In Bangladesh, median duration of breastfeeding is 32.8 months. However, the mean duration of exclusive breastfeeding is only 1.8 months. We describe an innovative intervention which attempted to integrate promotion of lactational amenorrhea method (LAM) with a community-based maternal, neonatal and child health program in a rural Bangladeshi community, where contraceptive use rate is low.

Intervention/activity tested
The intervention consists of (i) systems and capacity strengthening by training of the health and family planning providers and facilitates their activities and, (ii) community-based advocacy and behavior change communication that is targeting pregnant and postpartum women and their families. Female community health workers, one per 4000 population, conduct one antenatal and four postpartum home visits during which they counsel families on pregnancy and newborn care, the lactational amenorrhea method (LAM), transitional methods and on healthy timing and spacing of pregnancy. Community Mobilizers, a pair - consist of male and female per 20,000 population, organize advocacy and community meetings with pregnant and postpartum women, their mothers-in-law, husband, community influential persons including religious leaders, their wives; and identify postpartum women to serve as role models on LAM.

Methodology
The project has a quasi-experimental design. It follows 4430 pregnant women in rural Sylhet district of Bangladesh longitudinally from pregnancy to 36 months postpartum at 8 time points – baseline during pregnancy and at 3 month, 6 month, 12 month, 18 month, 24 month, 30 month and 36 month after delivery. Data will be analysis in different times to measure knowledge on contraceptive methods and healthy timing and spacing of pregnancy, LAM and other method use rate and finally pregnancy interval and its effects on birth outcomes will be measure. The intervention has been implemented since December 2007 and will be completed by September 2011.

Findings
At three months postpartum the LAM use rate was 34% in the intervention group compared to 14% in the comparison group. In intervention group, 49% of women at three months postpartum accepted any contraceptive method, compared to 30% in the comparison group (p<0.001).

Lessons learned
The inclusion of LAM counseling in a maternal and newborn care program, demonstrates significant potential for increasing contraceptive use among postpartum women during a particularly vulnerable period, the first six months postpartum.

The Influence of Birth Spacing on Child Survival Beyond Infancy in Nigeria (evidence from Nigeria Demographic and Health Survey, 2003)

Oluwumi Olatunji Alabi
Obafemi Awolowo University, Ile-Ife, Osun State, Nigeria; Nigeria; yomistoriil@yahoo.com

1) Background/Significance
World over, under-five mortality is of major concern to various government because of the role it plays in the classification of the world nations into the “developed” and “underdeveloped” categories among under uses.

Under-five mortality is unacceptably high in Nigeria. It has however been observed that this under-five mortality can be reduced in almost every country and the less developed countries in particular, if mothers spaced their births at least 3 year apart. Despite different attempt in the past to study the relationship between child health outcomes and child spacing in Nigeria, impressive reduction in infant and under-five mortality still experience serious set back due to high prevalence of unmet family planning needs in the country which was estimated at 17% in the year 2003 (NDHS, 2003).

Objectives:
The objective of this study is to understand the influence of child birth spacing on indicators of child health outcomes. The specific objectives of the study among others include:

a) To examine whether short child spacing is an independent risk factor for reduced child survival.
b) To ascertain whether this possible association is confounded by other socio-demographic factors specifically, maternal education, religion and wealth status.

Methodology: Considering data from Nigeria Demographic and Health Survey (NDHS, 2003), the author employed descriptive study to evaluate the effect of child spacing on under-five child survival in Nigeria.
Findings: Out of the total 7620 respondents sampled in the survey, 2180 under-five children was used in the analysis (representing the birth to women at least two birth given birth to in the five year preceding the survey), more than half were male (51%) and 49% were female- a sex ratio at birth of 1.04. Majority (79.4%) were reported to be alive while 20.4% were reported dead as at the time of the study. Considering the size of child at birth, 43% were reported to have large size at birth while 14% were reported to have small size at birth. Furthermore, 42.6% of the birth were spaced between 2-3 years, 29.6% were spaced less than 2 years while 27.8% were spaced 3 years or more. At bivariate level, type of maternal religion, educational level and child’s size at birth were found to be significant predictors of birth interval (p<0.05). Furthermore, all the above variables including birth intervals (p<0.01) were also significant in predicting child’s survival (p<0.05) at the bivariate level of the analysis. Other revelation from the analysis was the non significance of child’s health indicators like “child having fever in the two weeks preceding the survey”, “had diarrhea” and “had convulsion” in predicting the child’s likelihood of surviving (p>0.05).

However, at the multivariate level of analysis, employing binary logistic regression model to ascertain the specific objectives, it was revealed that women who spaced at least 2 or more years stand a higher likelihood of child survival than those who spaced less than 2 years (exp.(B)=1.532;p<0.05). Similarly, women of lower wealth status were more likely to experience under-five child death than their counterparts in higher wealth quintile (exp.(B)=2.138;p<0.05).

Knowledge Contributions:

Conclusively, the findings revealed that to reduce the high under- five mortality currently being experienced in the country, mothers should be enlightened to space their birth at least two years apart using appropriate family planning method available in the country. Also, of high importance is the issue of poverty reduction in the country if which addressed well by the policy makers as well as implemented, it will go a long way in reducing the current high under-five mortality in Nigeria.

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Empowering Communities to respond to reproductive health, maternal mortality and mobility in Delta State, Nigeria

Ufuoma Festus Omo-Obi1, John Uche Ishiekwene2, Akporobome Ashehe

1Christian Aid, Nigeria, Nigeria; 2Deux Projects Nigeria Ltd; 3Positive Peer Club, Delta State, Nigeria; ufostat123@yahoo.com

BACKGROUND

Nigeria’s maternal mortality rate continues at an unacceptably high level. Presently Nigeria account for 10% of the global estimate of maternal mortality. Estimates of maternal deaths are under reported by as much as 50% because most maternal deaths occur outside facilities and are not counted for many reasons especially in rural communities. Estimates suggest approximately 54,000 women and girls die each year due to pregnancy-related complications in Nigeria. Additionally, 1,080,000 to 1,620,000 Nigerian women and girls will suffer from disabilities caused by complications during pregnancy and childbirth each year; substantial numbers suffer long-term morbidity including vesico-vaginal fistulae, infertility and chronic pelvic disability. The tragedy – and opportunity – is that most of these deaths can be prevented with cost-effective reproductive and family planning health care services. Reducing maternal mortality and disability will depend on identifying and improving services that are critical to the health of Nigerian women and girls, including antenatal care, adequate postpartum care for mothers and babies, and family planning and STI/HIV/AIDS services by growing a critical mass of leaders who will serve as maternal and reproductive health rights advocates and contribute to reducing the current burden at the community levels.

METHODS

The Leadership Development and Skill for Health framework (LDP-SFH) was developed based on UNDP – LDP Framework. The project was initiated by Positive Peer Club, a community based organization that function basically from an integrated faith-based perspective, with support from Youth Network on Population and Development in Nigeria (YNETHA); collaboration with United Nations Development Programme (UNDP) & National Agency for the Control of AIDS in Nigeria (NACA) and funded by Deux Project Nigeria Limited. The program was designed to include series of leadership development skill building trainings followed by structured practical experiences to link theory with practice and mentoring in three months beginning from April 2006 – December 2008.

STRATEGY

The LDP SFH was aimed at stepping down the LDP framework to generate and grow a critical mass of leaders who will serve as reproductive, maternal and child health advocates and contribute to reducing the current burden at the community levels. While providing the leadership that would advance and ensure the reproductive rights of young people are realized across traditional, political and religious divides. Thus Community Youth Volunteer (CYV) Leaders were empowered with Leadership competencies using the LDP framework mainstreamed with strategic capacities on community reproductive & maternal health and HIV/AIDS prevention from a youth and Skills for Health (SFH) lens.

OUTCOMES

At the end of the project and capacity development; four teams were formed based on the interest of CYV with gender consideration. Breakthrough initiatives formed were: Life Builders Team (LBT), Save the Child Initiative (SCI), The Building Empowering and Effective Families (The BEEF Team) and The Innovative Team with various mandates to reduce maternal health and advance the reproductive rights of young people. The collective efforts of these teams have led to improved Assess to reproductive health care services; Development of community based plan strategies to address deficiencies and emergencies and Increased political, popular support for appropriate action; and Local monitoring and evaluation of local health systems and service delivery points over time

Lessons Learned/Recommendations

Based on the interventions carried out so far by the teams, the following are recommended and considered as priority actions that will improve reproductive rights, maternal and neonatal health and should be considered in Nigeria’s effort.

- Increased access to reproductive health, sexual health, and family planning services, especially in rural areas will reduce maternal deaths and complications in women of reproductive age (WRA)
- Increase access to high quality antenatal care, provision of prompt postpartum care, counseling, and access to family planning and improve post abortion care.
- Strengthen family and reproductive health promotion activities at grassroots and community levels
- Increase access to skilled delivery care

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Costs and benefits: Ever used contraceptive, family size and under-5 child surviving trend in Nigeria (1990-2003 as case study).

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Ayotunde Titilayo, Ojo Melvin Agunbiade, Oluyomi Olatunji Alabi
Obafemi Awolowo University, Ile-Ife, Nigeria; liasuyotunde@gmail.com

Background

Due to its substance in determining life expectancy at birth and the general extent of overall developmental level of any society, study of a country’s infant and under-5 survival rate cannot be overstressed. Though, reporting and recording of vital events especially death has not been accurate in less developed countries (LDCs), Nigeria inclusive, but the good work and the paradigm of study of the past 3 Nigeria Demographic and Health Survey (NDHS) (1990, 1999 and 2003) has been of immense assistance and reference point to social and epidemiology researches.

Reducing infant and under-5 mortality has been a serious concern of many in LDCs; in Nigeria it has been on the program of public health, national and international bodies for sometimes now. Researches have revealed many socio-economic and biological factors influencing high infant and under-5 death in LDCs which were classified into micro- and macro-level. But despite all concerted efforts to reduce under-5 mortality in LDCs, the highest risk of death among childhood is still recorded in these countries (sub-Saharan Africa countries in particular).

It has been observed overtime that the countries with the highest rates of fertility also have the highest rates of infant and child mortality. With less than 30 percent of all women having used a family planning method and a current TFR of 5.7 in the country, Nigeria belongs to the League of Nations with highest TFR worldwide. The country’s under-5 mortality rate within the 1999-2003 periods was 201 in every 1,000 live birth. Though, the 2008 NDHS preliminary report states a reduction in under-5 mortality (157 deaths per 1000 live birth). The authors would have loved to use 2008 NDHS data in this study but due to its unavailability for public consumption as at the time of this report.

Research questions/Hypothesis

1. What is the trend in contraceptive adoption within 1990-2003 periods in Nigeria?
2. Does the trend in ever used contraceptive move in the same direction with total fertility rate in Nigeria?
3. Is there any consequential relationship between family size and under-5 mortality in the country?

Methodology

The NDHS survey is a rich nationally representative database. Sequel to the aim of designing measure for the levels, patterns, and trends of demographic and health indicators, it provides up-to-date information on the population and health situation of the country. Specifically, among others, NDHS questionnaires collected information on the maternal, birth history and childhood mortality.

To have a nationwide coverage, NDHS systematically selected its respondents across all the geo-political regions of the country. NDHS with systematically selected 7620, 9810 and 8781 respondents (in 2003, 1999 and 1990 respectively) cut across all geo-political zones of the country.

With the aid of relevant variables from 1990 to 2003 NDHS data (like ever used contraceptive, total CEB, number of under-5 death, etc.), this study examined the effect of contraceptive adoption on family size and the consequential trend of under-5 mortality in Nigeria within 1990 and 2003 period.

Findings

It was discovered among others that the rate of ever used family planning increased from 19 percent in 1990 to 29 percent in 2003. Total number of women having 5 or more children reduced from 31.3 percent in 1990 to 29.4 percent in 2003. Though there is no statistically significant relationship between ever used contraceptive and total children ever born (CEB) in 1990 but 2003 data show a p value less than 0.05 relationship between ever used and total CEB. Considering the total children ever born and under-5 death in the country, majority (67.2% and 67.6% in 1990 and 2003 respectively) of women who reported 5 or more children ever born experienced at least one under-5 death (p<0.001) within the period 1990 and 2003.

Knowledge contribution or lesson learned

Conclusively, the paper confirms use of contraceptive as a principal predictor of total number of children ever born as already stated in many literatures but found family planning usage as a rather proximate determinant of under-5 survival in Nigeria and thereby calls for an active education of women on the use of family planning to make them see the relationship between the usage and childhood death.

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Fertility Regulation Among Women in Reproductive Age Group in Ibadan
Michael Abiola Okunola, Akinlade Olawumi Adeleke, Adewobale Abimbola Olutayo, Stella- Maris Ngozi Okonkwo
University College Hospital, Ibadan, Nigeria., Nigeria; templecity108@yahoo.com

BACKGROUND:

It is not uncommon to find parities like para 2+3,para 1+4 in our clinics.The +3 and +4 are usually voluntary termination of unwanted pregnancy to prevent an unwanted child. One wonders why they did not prevent the pregnancy in the first place?

HYPOTHESIS:

Women in the reproductive age group cannot bargain sex and prefer abortion to use of contraceptives as a means of fertility regulation.

METHODODOLOGY:

A structured questionnaire was administered to 450 women in certain areas of Ibadan including schools, offices and market places. The questionnaires were administered by trained research assistants in the department of gynaecology in the university over a period of 2 months.

FINDINGS:

35% of the women reported controlling their fertility through contraceptive use alone, 28% through reliance on both contraceptives and abortion and 47% through abortion alone. 15% did nothing to control fertility. 72% of the women had poor in depth knowledge on contraception. Level of education and socioeconomic status affect the uptake of contraceptive methods.

LESSONS LEARNED:
There is a need to educate the people of Ibadan on the need to use contraceptives instead of abortion as a means of fertility regulation. This will help to reduce unwanted pregnancy and also reduce maternal mortality figures from unsafe abortion and its complications.

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Expanding Use of Longer term Contraceptives Methods: Reaching the rural populations using outreach interventions in a culturally sensitive communities

Kolapo Oyeniyi, Obi Olugbode, Chris Enenche, Fatima Muhammad
Society for Family Health, Nigeria; koyalniyij@sfhngigeria.org

Background and Intervention Approach:
The adoption and use of contraceptives in communities where majority of the populace are low literates are often very challenging. This scenario may be compounded when there is religious and/or cultural connotation to the issues surrounding the adoption and use of contraceptives to space child birth. The resultant effects are summed-up in the unmet need for family planning, high fertility rates and morbidity & mortality due to frequent child bearing.

Intervention

The outreach intervention was employed to address these identified barriers. The objectives were to highlight the health benefits of using child spacing methods, promoting the advantages of the longer-term methods and bringing service delivery nearer to the rural population groups. This paper presents the experience in Nigeria.

Methodology:

From NDHS surveys, states with highest unmet need for Family Planning were listed. These included Bauchi, Gombe and Borno states in the North East of Nigeria. Within Bauchi state, some rural communities were identified based on population size and perceived needs for child spacing services. These rural communities were visited, assessed and mapped for intervention. The Outreach intervention commenced with the identification, selection and training of volunteers from the communities (including some with health background) to create awareness of the intervention. Some of the aims of the intervention were to initiate community group discussion on family planning, provide counseling services and mobilize women to attend clinics for service delivery on days set aside as event days. The community mobilization process is scheduled to start at least five days to one week preceding the event days. The event days ran consecutively for four working days (8.00am - 4.00pm).

The outreach event is integrated with other related reproductive health services such as HIV counseling and testing, provision of long lasting insecticide treated nets, STIs screening and testing for cervical cancer.

Findings

The mass turn-out of FP acceptors and increased uptake of the longer term methods suggests that many people within these locations are in need of these services. The uptake is usually very substantial on the first event day, and still tends to increase significantly over the remaining three days as beneficiaries and satisfied users go to mobilize other community members (their friends, family members and neighbours) to access the services. Evidence has shown that women who are unable to visit the health facility on the stipulated event days of the outreach intervention continue to visit and access services long after the outreach event. Some have followed the outreach services where it is being implemented in nearby communities.

Lessons learnt

The outreach intervention provides a veritable opportunity to reach very remote and underserved communities with quality child spacing services. The use of community volunteers who are familiar with the cultures and traditions of the locality as well as being known faces by the community members appears to contribute in overcoming some barriers.

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Should Short Term Hormonal Methods continue dominating the contraceptive mix in Sub Saharan Africa?

Jean-Pierre Manshande 1, Joana Kruse 2
1 Population Services International (PSI), Madagascar; 2 Johns Hopkins University, School of Public Health; jmanshade@psi.org

1. Background/Significance

Over the last decades important resources have been devoted to expand family planning programs to improve women's health and relieve demographic pressure. However, the effect on fertility in Sub-Saharan Africa (SSA) is slow to materialize and the region is characterized by persistently high TFR. The public health network is often dysfunctional, the private health sector nascent and often limited to urban areas, and the supply and distribution system for pharmaceuticals is hindered by lack of infrastructure. Therefore, technical and financial partners have traditionally favored the over-the-counter promotion of subsidized contraceptive methods using social marketing. Thus, the contraceptive method mix is in favor of short-term-hormonal methods (STHM), and information on long-term methods (LTM) is not readily available to users, particularly in rural areas.

2. Research: State main question/hypothesis

Program: State intervention/activity tested

We aim to evaluate whether the focus on SHTM is indeed appropriate for SSA. Additionally, we would like to analyze whether reduction in TFR could not be achieved with a switch from STHMs to LTM convergence, given the fact that modern contraceptive prevalence rate is unlikely to change in the short run, its determinants evolving very slowly (women's knowledge about contraceptives, urban/rural habitation setting, socio-economic status, education level).

3. Methodology (including location, setting, period, analysis approach)

The variable of interest is the TFR. The primary descriptive analysis considered the percentages of women utilizing modern methods of contraception, grouped into STHM (the pill, condoms, injections, foam and jelly) and LTM (intra-uterine device, implants, sterilization).

A review of current literature was undertaken to evaluate the switch of STHM to LTM in SSA. The effectiveness of STHM and LTM to achieve a reduction in TFR are evaluated based on failure rate, discontinuation rate, and costs to the system and to the user of various methods of contraception.

4. Data (if relevant)

For the descriptive analysis we used available data from the Demographic and Health Survey since 1997 grouped into three regions: SSA (32 countries), Latin America and Caribbean (8 countries), and South and South East Asia (8 countries), disaggregated at the urban/rural level and at the province level.
5. Findings

At the country level, on average TFR in SSA countries is significantly higher than in the other regions for the same level of modern CPR. However, the differences between SSA and LAC do not persist at the urban rural level.

Furthermore, the impact of LTM on TFR is higher in SSA than in the other regions, and therefore significant reductions in TFR could be achieved by switching to LTM.

When grouping countries by the predominant method of contraceptive among the pill, injections and long-term methods (IUD and implants), the data at the province level indicates that for the same CPR, countries that predominantly have LTM users have a lower TFR by about 1 point.

A literature review of the relative effectiveness of current modern contraceptive methods revealed that there is little information available to policy makers on the use of LTM in SSA. Furthermore, there are no reliable assessments of the impact of health infrastructure coverage, contraceptive supply and distribution, and access cost for contraceptives on TFR. Often these determinants are artificially considered functional when advocating for STM. Projections used for policy-making continue to be based on contraceptive methods failure rates assessed in the US, which fail to correct for the particularity of SSA settings.

As a result, the advice provided to both policy makers and users is inaccurate.

Available information suggests that LTM are more suitable than SHTM since the latter have higher failure/discontinuation rates, and are more dependent on adequate health coverage and functional supply chain. Thus, STHM is less effective than LTM in preventing unwanted pregnancies.

A recent paper, conservatively applying the US-based typical failure rates to SSA, estimated that shifting only 20 percent of the STHM users to implants could prevent 1.8 million unwanted pregnancies over a five-year period.

6. Research: State knowledge contribution

Program: State lessons learned

The current reliance on STHM to reduce fertility in SSA is inappropriate given the better performance of LTM. Further research is needed with a focus on SSA, however we argue that the policy should focus now on LTM which will have a higher impact on TFR. Future research should include a former meta-analysis of available data to enhance policy decisions.

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The Supply-Demand-Advocacy FP Program Model at Work: Case studies from Kenya and Azerbaijan

Holly J. Connor, Erin K. McGinn, Mavudza Babamuradova, Frederick Ndebe
EngenderHealth, United States of America; emcgin@engenderhealth.org

1. Background/Significance

Emerging from decades of family planning program experience, our own and those of other organizations, EngenderHealth has developed a holistic model of family planning/reproductive health programming called the Supply-Demand-Advocacy (SDA) Program Model. The SDA model serves to conceptualize, organize and guide EngenderHealth’s work. The SDA model approaches an FP/RH program by emphasizing the importance of the areas of supply, demand, and advocacy (and policy), holding that potential synergy among these program areas can be fostered via a coordinated package of mutually reinforcing interventions and that implementation of an SDA approach will ultimately improve FP/RH program outcomes.

[Visual of the SDA model available, but not able to display on electronic submission template.]

2. Research: State main question/hypothesis

Program: State intervention/activity tested

How has a comprehensive Supply-Demand-Advocacy approach to FP/RH programming in Azerbaijan and Kenya had an impact on strengthening family planning services and improving method knowledge and uptake?

3. Methodology (including location, setting, period, analysis approach)

This presentation will provide an overview of the SDA Program Model and describe its implementation in two diverse settings: 13 Kisii district (Nyanza Province) of Kenya (2005-2007), and in 60 health facilities and 45 pharmacies in six districts (with total population 567,000) and Baku (capital, population 4M) of Azerbaijan (2004 – present). In both settings, multiple interventions of each component (Supply, Demand, and Advocacy) were implemented.

4. Data (if relevant)

5. Findings

Kenya

In Kisii, the SDA approach to IUD revitalization was mapped over time. This graph clearly illustrates how supply and demand interventions have an impact on IUD uptake. Note that this data was collected for one year following the end of interventions, and also captures the negative impact that staff transfers and political unrest had on service provision and IUD uptake.

[graph available, but not able to display on electronic submission template.]

Azerbaijan

The Azerbaijan project is in progress, so a similar display of available data has not yet been generated. Nonetheless, this ongoing project is perhaps the most robust example of EngenderHealth’s SDA approach to FP programming. An example of interventions include:

Supply
• Contraceptive supplies improved; pharmacists have a three months’ supply of at least three modern FP methods in stock.
• More than 1600 service providers were trained on FP counseling and IUD insertion; 111 pharmacists were trained on essential FP information.
• Ninety-four percent of target health facilities are “readied” (have trained provider, BCC materials and job aids, private rooms, basic equipment and supplies to provide FP).
• Client satisfaction of service sites is 96.9 percent.

Demand
• Over 470,000 educational brochures have been distributed.
• Currently 267 peer educators are active in 67 communities.
• Sales of socially-marketed contraceptive products in project pharmacies have increased (pills up 31%, condoms up 22%, IUDs up 700%)
• TV ads for "Pregnancy Planning – Choose the Right Time" are seen by more than 75% of all women age 25-40 in Azerbaijan.
• A poster campaign in the 10 busiest Baku metro stations reaches an estimated 500,000 commuters each day.
• Project staff are now coordinating with other organizations working on the development of a national communication strategy, so that this project’s communication and media expertise and messaging can be incorporated into the national effort.

Advocacy & Policy
• Worked with other national level stakeholders to include contraceptives on the essential drug list.
• Worked with a national working group to develop a national RH strategy
• Led the development of nine national guidelines and protocols on FP methods.
• Provided TA to parliamentarians on a draft RH law.
• Strengthened teaching in FP/RH in pre‐serve institutions.

6. Research: State knowledge contribution
Program: State lessons learned
The development and application of a holistic Program Model is an ongoing need for any organization working in family planning/reproductive health. While most organizations have a history of approaching FP programming from a particular angle (services strengthening, demand-creation/BCC, or advocacy/policy), EngenderHealth is currently working to operationalize its FP/RH programs from a broader perspective. There are limitations to this approach, primarily where donor funding and direction does not support holistic programming, or may even exacerbate a disconnect between supply, demand, or advocacy/policy-related interventions implemented by NGO partners. For instance, it is common for one RFA to focus on supply side/systems strengthening, while another RFA may focus on BCC interventions. Nonetheless, EngenderHealth has found added value and impact when the SDA Program Model approach is implemented.

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Profiles of Male and Female Consistent Condom Users in Nairobi, Kenya
Gwenloyd Tate Morgan
African Population and Health Research Center, Kenya; gmorgan@aphrc.org

1. Background/Significance
Barrier methods, including male condoms, require a high level of consistent use in order to be effective in preventing unwanted pregnancy and HIV. People in “regular” relationships who rely on male condoms for protection against unwanted pregnancies and/or HIV tend to be inconsistent in their use as it requires a high level of motivation and self-control over a period of several months or even years. Yet the risks for unwanted pregnancies and HIV are often greatest among couples in such relationships.

Promotion of consistent condom use is often a key objective of programs seeking to reduce unwanted pregnancies and HIV incidence. In order to promote consistent use more effectively in such programs, it is important to understand the motivations, abilities, and opportunities to use condoms among those who do not use condoms. However, in quantitative population-based research in Kenya and elsewhere in Africa, the proportion of the study population reporting consistent use of condoms with a regular partner is often quite low; often too low to predict consistent use in a meaningful way. It is also quite difficult to recruit such people in a qualitative study due to difficulties in screening and identifying these relatively rare respondents.

2. Research Hypothesis
This research seeks to: describe the motivations, abilities, and opportunities for condom use among unmarried men and women aged 15-35 years living in Nairobi, Kenya who report consistent condom use with a regular partner.

3. Methodology
Qualitative interviews using a structured, open-ended guide were carried out with eleven men and seven women in Nairobi in April 2005 during a 10 day period. During this time, Population Services International (Kenya) conducted a national urban Behavior Change Communication Tracking Survey which explored (among other topics) condom use behaviors among males and females in thirteen of Kenya’s largest towns and cities, including the capital, Nairobi (n=514). Nairobi-based respondents for this survey who reported being between the ages of 15 and 35, who were unmarried, who currently had a regular sex partner, who report that they used condoms at last sex with this partner, and who report that they almost always or always use condoms with their regular partners were invited to participate in a second interview. All respondents who met these criteria (n=18) were identified and interviewed by a different research assistant with a qualitative instrument.

Questions explored on this instrument included first experiences with condoms, knowledge and attitudes towards condoms, as well as experiences using condoms with their current regular partner, condom buying, and condom use patterns.

4. Findings
Factors which may serve to facilitate consistent condom use among males include:
• Older age and higher level of education than the average male youth
• Early explanation and support of condom use by an older relative
• Experience and successful past negotiation and use of condoms
• Development of habits which support consistent and successful condom use (regular advance purchase, “stocking”, and correct use of condoms)
• Good negotiation skills – using reasons which appeal to women (e.g., prevention of pregnancy, cares and loves her) in order to use.
• Unusually high perceived social support from parents, older responsible adults, and friends
• Unusually high level of self-control and sense of responsibility in sexual matters
Predictive Factors for Contraceptive Counseling and Uptake after Post-abortion Care at the Private Providers Health Facilities in Western Kenya

Monica Adhiambo Onyango1, Monica Atieno Oguttu2, Mary Barger2

1Boston University School of Public Health, United States of America; 2Kisumu Medical and Education Trust, Kenya; 3Boston University School of Public Health, United States of America; monyango@bu.edu

1. Background/Significance:
Although significant strides have been made in the promotion of maternal health in Kenya, the maternal mortality ratio (MMR) remains high at over 400 per 100,000 live births. Abortions contribute up to 30% of all maternal deaths annually. Over 20,000 women are admitted each year for abortion complications to government hospitals.
Access to safe abortion services is restricted in Kenya and only allowed to protect the health or life of a woman. A woman found guilty of inducing an abortion faces seven years in prison and anyone performing an abortion can be sentenced to up to 14 years.

To expand opportunities for preventing unsafe abortions, a local non-governmental organization (NGO), Kisumu Medical and Education Trust (K-MET), recognized the potential contribution of private practitioners in post abortion care (PAC). Since 1996, K-MET has recruited, trained, equipped, and supervised health practitioners from government and private sectors on PAC in five of Kenya’s eight provinces. The practitioners run private health facilities offering PAC as a component of comprehensive reproductive health services. However, the post abortion contraceptive counseling and uptake has not been adequate at the private practitioners clinics in western Kenya.

This study was designed to better understand which women received contraceptive counseling and why some women do or do not get a contraceptive method after post-abortion treatment at the private health facilities in western Kenya. The main study objective was to establish factors associated with receipt of post abortion family planning (FP) counseling and contraceptive uptake at the private health facilities in Western Kenya.

2. Hypothesis Tested:
The two outcome measures examined were receipt of post abortion family planning counseling and going home with or without a contraceptive method.

3. Methodology:
This was a cross-sectional study conducted at 25 private health facilities in Western Kenya that were performing at least 10 manual vacuum aspirations (MVAs) per month to treat abortion complications. From July to October 2004 we interviewed 403 women who received post abortion care (PAC) via MVA. A 34-item structured questionnaire with closed ended and multiple-choice response questions was used for face to face interviews with women.

Data was entered in EPI Info version 3.2.2. Unadjusted and adjusted relative risks and 95% confidence intervals were calculated using log-binomial multivariable regression for categorical variables to determine association between selected variables and the outcomes of interest, either receipt of contraceptive counseling or going home with a contraceptive method. Stratified analyses were conducted to assess confounding. Statistical analysis was done using SAS version 9.1.

4. Findings:
Nurse-midwives provided the majority of PAC (55%). Among the women interviewed, 83% said their pregnancy was unplanned and 82% were treated for complications of induced abortion. Only 44% received FP counseling and one-third of women, 31% left with a contraceptive method. The strongest predictor for receipt of counseling was obtaining PAC at a low MVA volume facility (RR 2.33). After adjusting for volume, women who were younger and single were less likely to be counseled. Women who received FP counseling and those who had an unplanned pregnancy were 3 times more likely to leave with a method.

The strongest risk factor for leaving with a contraceptive method (adjusted RR=2.97) was receipt of contraceptive counseling during the woman’s post-abortion care. Half of the women who received counseling left with a method versus only 15% who did not receive contraceptive counseling. If the index pregnancy was unplanned, women were 3 times more likely to leave with a method after adjusting for marital status, parity, and receipt of counseling. However, women who had not had a previous pregnancy prior to this one were more than 40% less likely to leave with a method.

Participants reported that, on average, practitioners spent 27 minutes on counseling women who left with a method, and only 17 minutes on those who left without. Most women (90%) received counseling after the MVA procedure and 10% were counseled before the MVA procedure. A greater proportion of women (32%) who were counseled after the MVA left with a method compared to 21% counseled before the procedure.
Injectable contraceptives (Depo-provera) were chosen by the majority of the women (54%) followed by oral contraceptive (OCP) at 24%. Other methods women chose were female sterilization (8%), condoms (7%), implant (4%) and IUD (3%). Convenience was the most common reason mentioned for choosing a particular method. In conclusion, we recommend that busy facilities should consider training staff specifically for post abortion FP counseling. This may increase the contraceptive uptake following PAC. Facilities should also work with the ministry of health to ensure availability of a range of and adequate FP supplies.

5. Knowledge contribution: These findings emphasize the important role of contraceptive counseling in enhancing the levels of post abortion contraceptive uptake.

P4: 20

Community-Based Postpartum Family Planning in Afghanistan

Rahila Juya1, Holly Blanchard2

1Health Service Support Project (HSSP) Jhipego, Afghanistan; 2ACCESS-FP Baltimore; rjuya@jhipego.net

Background: Family Planning is a life saving measure. Thirty-two percent of maternal deaths and ten percent of childhood deaths could be averted if couples used family planning in countries with high total fertility rates. Current TFR in Afghanistan is 7.3 and CPR of modern methods 16 percent. The MMR is one of the highest in the world at 1800/100,000. Younger than five child mortality rate is 235/1,000. Research suggests that couples can reduce risks of poor pregnancy outcome if they wait at least two years after the birth of their last baby before trying to conceive again.

Hypothesis: Postpartum family planning (PPFP) increases contraceptive prevalence rate. PPFP includes promoting exclusive breastfeeding, lactational amenorrhea method (LAM), and encouraging transition to other methods of family planning to promote healthy spacing of pregnancies. PPFP provides information to couples on the benefits of healthy pregnancy spacing, return to fertility, and provision of family planning methods that are compatible with breastfeeding. Reinvigorating family planning through PPFP in conservative areas is more acceptable to communities than traditional promotion of family planning.

State intervention: The Ministry of Public Health (MoPH) with support from Health Service Support Project (HSSP) and Tech Serve invited non-governmental organizations to a standardized training of Community Health Workers (CHW) to revitalize family planning through PPFP. MoPH is advocating PPFP through initiating LAM as a gateway to other methods to achieve healthy pregnancy spacing. PPFP has been launched in 13 provinces in Afghanistan. The intervention includes:

- Advocacy:
  - PPFP advocacy at governmental levels from the governor to the health shuras;
  - Involvement of family health action groups (FHAG);
  - Orientation to PPFP for provincial level public health officials, community health workers, and district governors;
  - Orientation to PPFP at health facilities to in-charge and other relevant staff;
  - Orientation to PPFP for community leaders and mullahs; and
  - Reactivation of health shura by introducing PPFP.

- PPFP training package for CHW contains:
  - Healthy Timing and Spacing of Pregnancies (HTSP) to avoid pre-term/low birth weight neonates;
  - HTSP advantages of two or more years for the mother to breast feed her baby;
  - Breastfeeding practices;
  - LAM as a temporary family planning method;
  - Transition from LAM to other family planning method;
  - Return to fertility prior to the onset of menses;
  - Modern methods compatible with breastfeeding and a contraceptive timeline for breastfeeding practices;
  - Myths and realities about family planning;
  - Infection prevention;
  - How to initiate DMPA;
  - Communication skills; and
  - Islam and family planning.

- Developed performance standards for PPFP for the CHW and Community Health Supervisors (CHS). The performance standards provide an objective process to evaluate the services and promote quality assurance.

- PPFP services are added to currently scheduled visits: one late in pregnancy; another within 24 hours after delivery; another within three days after birth; and another at six weeks. During these visits the CHW assesses mother and baby, discusses the importance of exclusive breastfeeding, LAM, and provides some contraceptive methods. CHW then visits the mother again at three to four months depending on mother’s chosen method of contraception.

Methodology: Compare quarterly Health Management Information System (HMIS) reports from health posts in 13 provinces on numbers of family planning users before and after intervention from January 2007 through March 2009, illustrated below.

Data:

Findings: An increasing user trend is noted in the quarters after implementation of PPFP in October 2008 and expanded to all 13 provinces through June 2009. The services at the health posts are provided uniquely by the CHW.

Lessons Learned: Promoting postpartum family planning through healthy pregnancy spacing and LAM increased at the community level as measured by the number of family planning users at the health post. Advocacy is essential to promote community participation. The provincial public health officials, community health officers, district governors, staff at health facilities, community leaders, and mullahs were oriented to PPFP. Discussing the benefits of healthy spacing of pregnancies for mother/child survival through the use of modern contraception provides the basis to accept modern family planning.
P4: 21

Impact of UNFPA supported programs on substituting abortion as a Family Planning methods with modern methods of contraception

Tamar Khamasuridze, Lela Bakradze, Natalia Zakareishvili
United Nations Population Fund (UNFPA), Georgia; khomasuridze@unfpa.org

1. Background

Georgia, the post-soviet country experienced extremely severe economic recession after gaining independence in 1991. Civil unrest and armed conflict resulted in an economic crisis that affected the ability of the state to finance public expenditures. As the result, public expenditures on health declined dramatically. Expectedly, this drastic decline in public expenditures in a health system, primarily funded by the state led to the collapse of the health system. Widespread poverty, disparities between income levels and high cost of treatment led population to face economic constraints in accessing health care services.

In addition, country had experienced the challenges of depopulation and aging as a result of low birth rate and growing immigration due to rise in poverty and lack of opportunities in form of employment. Fertility rate fell below replacement level at 1.6 lifetime births per woman, which has lead to a population that is ageing with nearly 13 percent being over the age of 65.

Since independence the rates of MMR has doubled, from 20.7 in 1990 with highest peak 71.1 in 1997, in 2004 decreased to 45.3, in 2005 MMR decreased almost twice and became 20.2 per 100 000 live births. IMR has been improved since 1996. 2005-2007 were mentioned as decreasing tendency years, so in 2007 IMR had recorded as 13.3 per 1000 live birth.

Traditionally, as in all soviet countries there was heavy reliance on abortion as a means of fertility control due to the easy availability of abortion, matched by the poor availability of contraceptives and misconception about the modern methods of family planning. At the end of the 1990s, only one in five Georgian couples were using modern contraceptive methods. Limited access to family planning methods and services, lack of knowledge, negative attitude modern methods of contraception and their side effects has been the important barrier to utilization of family planning services among women of reproductive age.

2. Program: State intervention/activity tested

Impact of UNFPA supported programs on substituting abortion as a Family Planning methods with modern methods of contraception

2. Methodology

Desk Research using data of vital statistics and surveys

3. Findings

According to the vital statistics the trend in the total induce abortion rate from 1999 to 2005 per women ranged from 3.7 to 3.1, this figure is supported by the RHS data, which show that abortion rates in Georgia has declined by 16 per cent. In absolute numbers, since 1991 total number of abortions has declined twice, from 59, 384 to 20, 644 in 2007.

Unsafe abortion carries a high risk of mortality and morbidity. Official statistics on abortion-related mortality in Georgia are scarce; overall, complication occurred in 10 % of abortion cases in 1999 survey and 6.3 % in 2005, most of them occurred early rather than late.

In recent years, the balance has shifted from abortion towards contraception. The recent efforts by the UNFPA, both the availability of modern methods and the delivery of adequate information on modern contraception improved. Abortion in Georgia has declined, while more couples are using modern contraceptive methods. Between 1999 and 2005, almost 68,000 women started to use supplied methods of contraception. In fact adoption of modern contraceptives in Georgia occurred at a much faster pace than it did worldwide. From 1990 to 2000, use of modern methods in Georgia increased by 250 % compared to only 12 % worldwide. Trends in the use of modern contraception in Georgia between 1999 and 2005 increased from 20 to 27 percent.

After the Cairo Conference UNFPA started to provide assistance to Georgia. During these years the support provided to country became more comprehensive. In 1999 UNFPA established its full fledged Country office in Georgia and expanded its operations by funding programmes with primary focus on Reproductive Health.

UNFPA supports the Georgian Government in the implementation of the ICPD Programme of Action and MDGs. Activities and programmes are country-specific and tailored to meet Georgia’s needs in the area of reproductive health, population and development and gender, through addressing the topical aspects ranging from the quality and accessibility of RH services to gender equality and availability of quality data for development. UNFPA has approved several projects and through the multifaceted interventions addresses emergency needs, provides contraceptives and technical assistance to the Ministry of Health. UNFPA is one of the main providers of free of charge contraceptives to the country. During the period of 1996-2008 UNFPA purchased contraceptives worth more than 4 million and distributed free of charge to the public health sector. With UNFPA assistance, the RH centres provide quality RH services to the population. According to the developed RH plan essential components have been implemented such as training of national experts and RH service providers, nurses and midwives on RH issues; RH centres and RH Mobile Teams have been established and provided with medical equipment and supplies, information materials about RH issues such as safe sex, use of condoms, methods of family planning have been distributed. UNFPA developed the strategy to address multiple causes, building the barriers for utilization of family planning services, such as geographical accessibility, quality of RH services and affordability.

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Induced Abortion and its determinants in China

Xiaoying Zheng, Lihua Pang, Lei Zhang, Bizi Zhang, Sanjun Chen
Institute of Population Research/WHO Collaborating Center of Reproductive Health and Population Science, China, Peoples Republic of; xzheng@pku.edu.cn

1. Background/Significance: Research/WHO Collaborating Center of Reproductive Health and Population Science, China, Peoples Republic of; xzheng@pku.edu.cn

2. Research: State main question/hypothesis: Educational and developing situation of region where women lived will affected abortion level. If child gender will be affected the abortion??
Program: State intervention/activity tested
3. Methodology (including location, setting, period, analysis approach)
4. data (if relevant) Based on data from the 1988, 1997, 2001 and 2006 national sample surveys on Reproductive health which include the pregnancy history of married women, we use descriptive analysis to compare the abortion level among women with different characteristics and employ multivariate logistic regression to explore the determinants of abortion over time in China.
5. Findings
Within the last 2 decades, the level of abortion has been decline among all groups women by age, education and location, however, compared with 1990s when older, rural and less educated women dominate the induced abortion, the younger, urban, more educated women relied more on abortion in 2000s.
Age, education, rural/urban residence, pregnancy order, number and gender of child determinate the choice of abortion.
6. Research: State knowledge contribution
Program: State lessons learned
Women in both rural and urban China in the 2000s had changed their reproductive behavior, which was different from that in the 1990s and 1980s. Women with no children or in the early stages of reproductive age or with the first pregnancy in the 2000s aborted more fetuses than before, for those women did not sufficiently satisfy their contraceptive needs. Thereby, we should play more attention to newly married women and younger women, and provide much high quality reproductive health services to them. Women living in cities are more likely to postpone their marriage to late 20 years or even 30s, and still face high pressure from work after marriage, especially for those with better education, so women in urban areas always plan a later first birth. Communities should provide quality reproductive health services to those women in order to reduce the number of unwanted pregnancies and abortions as well. Meanwhile, the maternal and child health promotion should be strengthened in national and community level, as more and more families and couples would like to have a few child but very healthy, if no very quality services can be supplied, sometimes they will choose induced abortion based on their “risk experiences” which may not be the real risk for their pregnancy. In recent years, reproductive health has become one of the core courses in some high schools and colleges. However, the contents did not effectively satisfy the needs of people of reproductive age. In addition, most propagation targeted rural women, rather than urban women, particularly women with higher education. Then both government and communities should supply variant contraceptive services to offset the gap between unmet need and reproductive health services. Compared with women who chose abortion at higher pregnancy order or to meet the quota of number of children in 1990s and 1980s, more women chose abortion at their early pregnancy order and before they have a child. So, the reproductive health service should pay more attention to those new married couples to avoid they have to choose abortion for unintended pregnancy.
P4: 23
How can LA/PMs contribute to helping people achieve their reproductive intentions? An analysis of DHS data from 34 countries
Emily Sonneveldt
Futures Institute; lbakamjian@engenderhealth.org
1. Background/Significance: Long acting and permanent methods of contraception (LA/PMs) remain unavailable and underutilized in many countries, despite their high effectiveness rates and low costs. Women with an unmet need for both spacing and limiting pregnancies would benefit from increased access to LA/PMs by reducing the number of unintended pregnancies resulting from method failure, which would contribute toward their ability to achieve their reproductive intentions. However, increasing utilization of LA/PMs requires an understanding of current LA/PM users and how they differ from other modern method users, traditional method users, and nonusers. This information, along with other information on unmet need and reproductive desires, can be used to estimate the potential “market” for LA/PMs, creating strong evidence-based information on the potential impact of expanded access and utilization of LA/PMs.
2. Research: The overall goal is to understand how LA/PMs can contribute toward helping people achieve their reproductive intentions.
Program: This will be explored through asking two research questions: (1) Who are current LA/PM users, and how do they differ from other modern method users, traditional method users, and nonusers? and (2) What is the potential “market” for LA/PMs, how big is it, and what segments of the population are viable for increased program attention? Answering these questions will provide the information necessary to identify potential users and increase international and national interest in LA/PM programming.
3. Methodology: Secondary analyses of the most recent Demographic and Health Survey (DHS) (after 2000) in 34 countries were performed, using STATA to answer the above research questions. Additional analysis was performed to quantify changes in the number of unintended pregnancies resulting from more women using modern methods with higher rates of effectiveness. This will explore the effect of both increasing overall use of LA/PMs and increasing the LA/PM share of the method mix. This will also illustrate the relationship between effectiveness rates of contraceptives and unintended pregnancies, with a focus on differences between long-acting and short-acting modern methods.
4. Data (if relevant)
5. Findings: The proportion of the method mix attributed to LA/PM users differs significantly by region, with the African countries having the lowest utilization of both long-acting and modern methods, Latin America and the Caribbean countries having the highest use of permanent methods, and the highest usage of long-acting methods occurring in the Caucasus and Middle Eastern countries. No overall patterns were found for age or residence when comparing long-acting, short-acting, other modern, and traditional methods. However, analysis of parity and ideal number of children highlights a large variation by country and region, showing that in most countries, women who are using permanent methods of contraception have already exceeded their preferred number of children.
In addition, although most DHS surveys find that the majority of women can name at least one type of modern method, disaggregating knowledge data here shows that there is still a need to disseminate information about a variety of contraception methods. Findings show that few users of long-acting methods can name both the IUD and implants; few users of short-acting methods can name any long-acting or permanent methods; and few users of traditional methods can name any short-acting, long-acting, or permanent method.
Finally, to identify the potential “market” for LA/PMs, data on unmet need for spacing, unmet need for limiting, and numbers of postpartum women were combined with current use of LA/PMs to create various definitions of demand for LA/PM. This information is used to estimate the number of potential LA/PM users and identify segments of the population that would benefit from increased access to and information on LA/PM. This analysis finds that there is a large market of potential LA/PM users that would benefit from increased access.
6. Research: Research Evidence
Program: Increased utilization of LA/PMs would assist individuals in meeting their reproductive intentions and countries in meeting their national and international targets, such as the Millennium Development Goals. However, this will not be possible without a clear understanding of the potential impact of
increased utilization and the existing demand for these methods. Providing this information to countries can play a large role in advocating for increased resources and programming for LA/PMs.

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Spousal communication on family planning as a safe motherhood option in sub-saharan African communities

E.O Orji, C.A. Adegbenu, B.I Akinniranye, O.G Ogunbayo, A.E. Oyebadejo
Obafemi Awolowo University, Nigeria; Calebade2002@yahoo.com

Objective To explore the level of spousal communication in family planning and to gain insight into factors militating against this in Ife Central Local Government area, Osun State, Nigeria with the aim of enhancing men participation in safe motherhood. Methods This is a community survey using both quantitative and qualitative data collection methods. The quantitative data was collected using semi-structured interviewer administered questionnaires while the qualitative data was collected using gender and age-specific Focus Group Discussions. A non-probability sampling method was employed. Data was analyzed using the Statistical Package of Social Sciences (SPSS) software version 13. Relationships between discrete variables were tested by means of chi-square test. Whenever expected cell frequencies were less than five, the likelihood-ratio Chi-square values were quoted rather than Pearson’s. Statistical significance was accepted at P-values of <0.05. Results Four hundred married couples (166 men and 234 women) were interviewed. While majority 383 (95.8%) of the respondents have heard of family planning only 200 (50%) of the total respondents had discussed family planning with their spouse at least once. Focus group discussions revealed that majority of the men had difficulty discussing family planning with their partners because they felt it was a sign of promiscuity and it was not necessary. The female respondents on the other hand are afraid of rejection and opposition from their partners. There’s a gradual decline in the spectrum from awareness to actual use, compliance and spousal communication in the rural area. Conclusion Spousal communication about family planning should be encouraged in rural areas of Nigeria. Since men as well as women, play key roles in safe motherhood, communication is necessary for making responsible decisions.

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Making Reproductive Health Commodities Available on a Large Scale: The Example of Misoprostol

Melodie Holden, Ndola Prata
Venture Strategies Innovations, United States of America; mholden@venturestrategies.org

Background/relevance

A major challenge in family planning and reproductive health is ensuring that adequate supplies of high quality commodities are available throughout countries. The example of misoprostol illustrates the opportunity to work with Ministries of health and the private sector to make this happen. For five years, Venture Strategies has successfully addressed this challenge by creating and increasing access to misoprostol for women in 14 countries in Africa and Asia. Misoprostol is a life-saving generic drug used for obstetric and gynecological indications including prevention and treatment of post-partum hemorrhage (PPH), post-abortion care and safe abortion.

Using examples from the field, this session will describe how challenges in the following areas have been addressed:

• securing supplies of quality products which are affordable to the poor and widely available in urban and rural areas
• scaling up successful pilot programs
• instituting appropriate policy changes
• overcoming provider shortages by encouraging task shifting to appropriately-trained lower level providers
• building public/private partnerships
• ensuring sustainability

Program Intervention:

Our goal is to design and implement programs that create access to misoprostol and continue beyond our direct involvement. We describe four major strategies used to develop programs that address seven major areas critical for overall success.

Strategies

1. Set a goal for large-scale impact and make a plan to meet it. Successful pilot programs will only have an impact if they are brought to scale at a national level
2. Bring the right people together. Build coalitions, secure government commitment through education and advocacy, engage local agencies, and institutionalize programs through policy development
3. Train those closest to the action. Train appropriate levels of providers, implement in phases, and integrate with other programs and NGOs
4. Bring the product to the people, to the people to the product. Engage communities, generate demand, establish distribution systems in the public, private and NGO sectors, and involve primary and community-level providers, facilities and leaders

Program Areas

1. Policy Development and Institutionalization: Create the policy environment and changes necessary for program sustainability
2. Operations Research: Together with the Bixby Center, University of California, Berkeley, we conduct operations research that provides data for policy makers to lower the level of provider permitted to access and use misoprostol
3. Regulatory Approval: Facilitate country registration and market authorization – governments’ legal approval for import and marketing of a manufacturers product
4. Manufacturing: Facilitate productive relationship building between multiple high-quality generic manufacturers and local drug distributors and negotiate price caps for products
5. Pricing: Quantify willingness to pay among target populations, examine all components of the pricing system, and negotiate price reductions at each point
6. Distribution: Define potential channels of distribution for misoprostol through both the public and private sectors. Design strategies that select channels with the maximum potential impact on the end users, pregnant women. Engage with government purchasing agencies, social marketing and franchising agencies, and private commercial distributors
7. Information, Education and Communication (IEC): Work with international and local partners to design and implement public health campaigns to educate and raise awareness of misoprostol

Outcomes

Ten countries in our program have registered misoprostol, five have included the use of misoprostol in their national clinical guidelines and four have included the drug on their national Essential Medicines List.

In our ongoing pilot programs, 9,920 providers have been trained to use misoprostol. Our work resulted in the distribution by VS and our partners of over 3 million tablets, roughly equivalent to 540,000 protected births.

Findings/Lessons Learned

- Registration of a product is a critical first step towards creating a sustainable product supply, but it is not enough to ensure large-scale program implementation
- Commodity prices can be reduced through, price competition, negotiation, policies, subsidization, startup investment, and high volume purchases
- Rural distribution can be achieved through engagement of both public and private sectors, social marketing, subsidization, and demand generation/IEC activities
- Services can be delivered at scale even with few skilled providers through task shifting, and by deploying simple-to-use technologies
- Programs must be institutionalized by updating clinical guidelines, essential drug lists, and provider curricula, and by using local implementers
- Success can be achieved in politically sensitive environments with pragmatism of local advocates
- South-south trade in needed generic commodities which includes the public and private sectors, can be brought to scale and implemented affordably to meet the needs of communities
- It is possible to develop countrywide programs when scale, pricing, and partnerships are developed at the outset of a program

Venture Strategies has developed a proven strategy to create and increase access to misoprostol, and is actively applying this strategy in many low-income countries. The strategy is based around several core strengths of the organization, yet is flexible enough to be applied to many other greatly needed proven medicines and technologies including contraceptive drugs and devices.

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Improving Access to Family Planning Service-Delivery Data: Experience from The RAISE Initiative

**Judy Austin, Sara Casey, Meghan Gallagher**

Columbia University, United States of America; JA2026@columbia.edu

1. Background/Significance

New and protracted conflicts across the globe ensure an ongoing demand for humanitarian relief and development aid. The success of emergency interventions and sustained health services, including family planning programs, can be greatly enhanced through the review of readily accessible, accurate routine monitoring data. Despite concerted efforts by experienced individuals and well resourced agencies, collection of reliable surveillance data for effective program management remains an ongoing challenge. The Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative is a 5-year project supporting existing NGO-led reproductive health (RH) programs in emergency settings in Africa, Asia and South America. The extended term of this program has provided a unique opportunity for the development of enhanced routine RH information systems and the exploration of alternate solutions to this perennial problem.

2. Program: State intervention/activity tested

Electronic facility-level reproductive health information systems were introduced at facilities, in conjunction with revised paper-based patient-level registers, to improve the evidence base available to support and inform management decisions.

3. Methodology

As part of comprehensive baseline facility assessments undertaken at 70+ facilities in the ten RAISE projects to evaluate current clinical functioning, including capacity to provide emergency obstetric care and family planning, existing HMS systems were reviewed. Indicators deemed essential to the management of a reproductive health facility were identified. Paper-based family planning-, labor and delivery-, gynecological-, operating theater-, and other reproductive health service registers in which patient-level data are recorded were revised, where necessary, in conjunction with partner agencies, Ministry of Health and RAISE Initiative reporting requirements. An RH-specific facility-level electronic data reporting system was developed through operational research.

4. Data

Existing systems for recording, aggregating and reporting Family Planning data to management were limited in eight out of the ten projects assessed.

5. Findings

It is clear that recording and reporting of FP and other RH program data is poor, making the resulting information unsuitable for guiding action to maintain and improve service-delivery.

Recording of individual patient data takes place routinely, but data are not stored in a manner that permits ready retrieval for aggregation and further analysis. A culture that includes reliable routine data collection, entry, reporting, analysis and interpretation has not yet been established, despite an expressed desire to do so. Yet, in the absence of good data, there is little opportunity for informed management decision-making, such as timely procurement of family planning supplies to avoid stockout. A step towards improving data quality is to reduce the number of indicators for which data must be collected and to ensure that their definition/structure is simple and clear.

Local staff will need training and encouragement to perform the additional tasks of data abstraction and entry into a reporting system to which they may initially be resistant. Data systems will not be incorporated as a facility management tool unless the benefits are demonstrated early in the process and reinforced throughout the transition period and beyond.

6. Program: State lessons learned
Challenges to the reliability of routine data collection arise from the excessive information recording requirements placed on already burdened staff, a lack of buy-in from middle management – often exacerbated by the delay in feedback and little evidence of data utility, the absence of funding for HIS system development within program budgets, a lack of dedicated personnel for data collection and record maintenance, high staff turnover - with concomitant loss of institutional memory, and reluctance to report data that reflect poor outcomes, leading to incomplete reporting.

Rather than expecting clinical staff to accept data abstraction tasks, specific funding should be included with which to hire dedicated personnel.

A minimum set of standardized indicators should be agreed upon for use in ongoing family planning and other RH programs. Data quality control measures should be incorporated. The RAISE Initiative is uniquely placed to explore these different options, to assess their utility over time and to identify an optimal approach to program data collection and use.

P4: 27

Fertility and caregiving in peri-urban Egypt

Daesh Ramachandran1, Andrew Stokes2, Omaima El Gibaly3, Mahmoud Mossallam1, David Bishai1

1Johns Hopkins University, United States of America; 2Bates University; 3Assiut University; dramacha@jhspih.edu

Background/Significance

Evidence from Pakistan, Bangladesh, and Algeria has supported the hypothesis that mothers in law have a pronatalist influence. New demographic developments have added complexity: 1) There is more chronic disability among adults as older generations live longer; 2) Extended families facilitate husbands’ circular migration to urban centers for work. Both the dependency burden of seniors and the extended absences of husbands may mitigate the effect of the extended family on both desired family size and fertility.

The foregoing considerations have led us to design a study that focuses on measuring how co-residence with a mother in law affects fertility. We believe that understanding the supply and demands on caregiver time can help us understand desired family size, the demand for family planning, and fertility.

Research Aims

In this study we aim to establish whether a co-residing mother-in-law alters fertility and the length of closed birth intervals.

Methodology

Using both DHS data and ELMS data, this study compares the parity progression of women with and without co-resident mother in laws. The dependent variable of interest is the likelihood of parity progression between the first and second child. The independent variables examined include co-residence with a mother-in-law, age (5 year age-groups), region (6 regions), and highest education level (4 categories). Bivariate and multivariate regression are used to identify the effect of mother-in-law coresidence on parity progression.

Data

This study uses 2 data sources: the Egyptian DHS 2000 (EDHS) and the Egyptian Labor Market Survey (ELMS). The EDHS is a nationally representative sample of N=16,957 households with 15,573 women age 15-45 collected by Zanaty & Associates. The ELMS is a nationally representative sample of 5,000 households surveyed in 1998.

Findings

Analysis of Egypt DHS showed an inverse correlation between adult and child dependency ratios as well as between adult dependency ratio and number of children under 5 in household (correlation coefficient = -0.13 and -0.14, respectively). Among households with no members, one member and two members over age 55, the child dependency ratios were 85, 55 and 54 (per 100 adults), respectively. Additionally, the data suggest that there is a statistically significant negative association between mother-in-law co-residence and parity progression rate; when controlling for age, region of residence and women’s education, women with a co-residing in-law were 25% less likely to move from parity 0 to parity 1 (p=0.000) and 29% less likely to move from parity 1 to 2 (p=0.000).

Preliminary findings thus suggest that co-residing with a mother-in-law is associated with delayed time to 2nd and 3rd birth. We hypothesize that this could be due to an increased likelihood of absent husbands in households where mother-in-laws reside. Analysis of the ELMS data is ongoing and will permit controls for whether the spouse often lives away from the household for work.

State knowledge contribution

By understanding how extended families influence fertility among Egyptian women this research is valuable in projecting how aging and future trends in elderly co-residence will affect the demand for family planning services in Egypt.

A08: National FP Policy and Advocacy II

Time: Tuesday, 17 November 2009: 4:00pm - 5:30pm

A08: 1

Effort Ratings for National Family Planning Programs

Ellen Smith, John Ross, Aditi Krishna

Futures Group International, United States of America; esmith@futuresgroup.com

Background/Significance

Seven times since 1972 an international study of developing countries has been conducted to assess the strength and types of national family planning programs. This time series of the Family Planning Program Effort Scores has created a unique reservoir of information that can be used to trace the history and performance of these programs. The 2009 cycle updates the 2004 cycle, and this presentation provides the latest picture of five-year changes in effort levels across 31 indices. Each cycle of the study has included about 85 developing countries, embracing all of the largest members of each region and more than 95 percent of the developing world’s population. The unique advantage of these indices is that they give a global picture, at one point in time, at reasonable cost, for a standard set of program features—which of some cannot be estimated except by this methodology of expert observers—and with replications over the years.

Main question

This study seeks to describe the national family planning program efforts that affect the developing world’s population. The Family Planning Program Effort Scores comprise 31 separate indices that measure (a) the policy context, (b) service provision, (c) evaluation and monitoring, and (d) access to each
contraceptive method, as well as to safe abortion. Each of these four components of effort is examined separately, as well as the effort profile across the 31 indices. An additional set of measures (in 2004 and 2009) assesses the changing context in which the programs operate.

Methodology

In order to capture the situation in many countries simultaneously, a collaborator who is highly knowledgeable about the national family planning program is identified in each country. This person has the responsibility of identifying 10–15 respondents to complete the standard questionnaire; these experts from a variety of agencies and professional backgrounds provide the ratings for the 31 indices. The questionnaires are analyzed centrally, with early feedback of data and interpretative charts sent to each country. This approach provides a unique complement to sample surveys, which have quite different strengths.

Data

This study collects data in the form of expert scoring of 31 aspects of family planning program effort. The cycles of the seven Family Planning Program Effort Scores (1972–2009) are used as a basis for trend analyses.

Findings

Findings to be presented include:

(a) The 2009 picture of program efforts, according to the four components and 31 individual ratings, by region and selected countries;
(b) The recent (2004–2009) trend, by the four components, by region, and by the full set of countries for the 31 ratings; and
(c) The longer trend (1982–2009) for the overall (total) index, first for the average country and second with population weights, since the two trends differ considerably due to the influence of the largest countries.

At this writing results are not yet in, but past patterns have shown that access to a variety of contraceptives is often the weakest of the four components. However, individual countries vary greatly in which methods lack access, whether it is sterilization (outside of Latin America and parts of Asia), the IUD (outside of the Middle East and parts of Asia), or other methods. Few countries offer a wide range of contraceptive options; most are strong in only one or two methods.

Other conclusions from the past research show that there is no single path to program effectiveness. Each country must identify policies and field methods that fit its circumstances. Some policies have stressed outreach through CBD workers, others through postpartum provision, some through the mainline health system, and others through commercial distribution. However the use of multiple approaches has been important. Finally, the creation of favorable policies has been stronger than services, and services have been stronger than actual access to a variety of methods.

Cross-country analyses will be provided regarding the relationships between program effort and the outcomes of contraceptive use and fertility change, as well as relationships to changes in unmet need and rates of unplanned pregnancies. Finally, lessons will be drawn for policy and program improvements and for adjustments to the changing contexts in which the programs work, including decentralization, integration, funding reversals, and attention to special populations.

Knowledge contribution

The Scores provide a rich dataset reflecting nearly 100 developing countries’ changes in many facets of family planning policy and services across time. The scores are used (1) to conduct trend analyses of changes in family planning programs across time, regions, and individual countries, (2) as inputs into causal analyses, to tease out the relative effects of programs and social settings, (3) to highlight programs’ strengths and weakness for advocacy purposes so as to encourage renewed high-level commitment for family planning programs, and (4) as a tool for governments and donors to set country priorities and gauge progress.

A08: 2

Family planning champions: Harnessing the innovative advocate

Tricia Petruney, Kate H Rademacher, Jason B Smith

Family Health International, United States of America; tpetruney@fhi.org

Background

Public health research is not an end in itself. Rather, research should ultimately inform and improve policies and practices. Unfortunately, a large gap still exists between the spheres of research and practice, leading to delays of a decade or longer before widespread use of conclusive evidence. Drawing from Everett Rogers’ Diffusion of Innovations Theory, seminal research utilization literature asserts that access to, understanding, translation, and uptake of research findings can be facilitated by influential local opinion leaders who assume the role of advocates or ‘change agents.’ In September 2004, Family Health International (FHI) launched an innovative pilot project called the Network of Champions. This initiative aimed to bridge the gap between research and action by identifying and supporting local ‘champions’ to promote key family planning research findings and advocate among policy-makers, health practitioners, and other decision-makers for evidence based policies and programs.

Program activity

Since 2004, FHI has managed Network of Champions initiatives with participants from Uganda, Zimbabwe, Tanzania, Nigeria, Pakistan, India, Ethiopia, and Zambia and also facilitated and participated in distinct but similar champion efforts for family planning in South Africa, Uganda, and Tanzania. Network of Champion participants are asked to promote awareness and utilization of under-used contraceptive technology and reproductive health research findings through partnerships with local stakeholders such as health professionals, policymakers, and advocacy groups. The project has been applied in two iterative phases. The first was implemented using an international, multi-topic approach. Champions were selected from seven countries and asked to promote a family planning issue of choice. In the second phase, champions from four countries collectively promoted the integration of family planning and HIV/AIDS. Deliberate efforts were made in the second phase to ensure that champions had clear institutional support from their organizations and supervisors.

Methodology

Monitoring and evaluation is ongoing for the project activities. In a presentation of our results we will strive to answer the following questions:

Why should a champion approach be used to promote family planning within national contexts, and what are the criteria necessary for successful outcomes?

What are the most important characteristics of a public health champion?

What levels of change should be expected from engaging different types of champions, and what timelines are appropriate for each level?
Is it possible to facilitate the development of individual champions by providing them with resources and support? If so, what specific inputs are needed to help create and nurture a champion?

How can public health organizations influence existing champions or opinion leaders such that they adopt a particular health issue and advocate for it?

What is the value added of a ‘network’ approach to engaging champions?

Program Achievements

Preliminary key achievements from the Network of Champions include the following:

A postpartum family planning protocol for maternity and postnatal care wards in Uganda was developed and piloted, and is proposed for inclusion as an essential component of the National Minimum Package for PMTCT services.

These protocols developed in the Uganda initiative will be scaled up to several other districts, and the champion has leveraged funds and partnerships with UNFPA and the CDC.


After a needs assessment showed high community demand for integrated family planning and HIV/AIDS services, the Private Nurse Midwives Association of Tanzania (PRINMAT) trained midwives from 20 clinics for provider-initiated testing and counseling for HIV.

Program lessons learned

Conference participants will gain a better understanding of why engaging champions as change agents to improve reproductive health is an important research utilization strategy, and will be able to name some of the key considerations for designing and supporting a champion initiative. Data collection and evaluation is not yet complete, but will enable FHI to share detailed recommendations. Based on program experience to date, recommendations likely to be included are:

Champions should make deliberate efforts to mobilize their own existing informal local networks thereby harnessing the power of their individual spheres of influence and increasing the likelihood of achieving policy or program change.

Incentives for champions are essential, and may be financial, professional, or personal.

If a network model is being applied, coordinators should be mindful of the advantages gained by ensuring that all champion have met one another, that the group has a common understanding of the project objectives, and understands each of their colleague’s chosen strategy and relevant activities.

Challenges to developing and sustaining an effective network model include champion turnover and inadequate access to technology. Implementing a national model rather than a cross-country international model may help to facilitate improved communications.

A08: 3

Advocating for Innovation: Community-based Provision of Injectable Contraception in Africa - Getting Past ‘No Way!’

Kirsten Krueger, Morissa Malkin, Crystal Dreisbach, Amanda Abbott
Family Health International, United States of America; mmalkin@fhi.org

Background/Significance

While Depo-Provera is a popular, safe, convenient and highly-effective family planning method, it is often difficult for women in rural areas to access clinics where injectables are provided. Results from a USAID-funded, Family Health International-Save the Children–USA collaborative study demonstrate the safety, feasibility, and acceptability of community-based distribution (CBD) of Depo-Provera in a rural Ugandan district. Clients of community-based workers (CBWs) were equally satisfied and continued use of family planning for as long as their clinic-going counterparts, and CBD of Depo-Provera appeared to be as safe as provision by nurses. Similarly, positive results from a 2007 collaborative study by Family Health International, Population Services International, and the USAID-supported bilateral, SanteNet in Madagascar led to the national scale up of the practice in that country. Community-based provision of Depo-Provera has the potential to dramatically increase women’s access to family planning by making this popular contraceptive method available conveniently, through trusted community members.

Despite a strong evidence base for CBD of Depo-Provera, many African countries resist this service delivery mechanism with the rationale that it is unsafe for clients to receive injections from paramedical personnel. Advocacy campaigns at the global and country level have raised awareness among donors, policy makers, and program managers about the feasibility and safety of the practice and the need to review existing policies and programs to allow community health workers to provide Depo-Provera based on training, not title.

Intervention/Activity Tested

Positive findings from studies in Uganda and Madagascar reinforce data from Asia and South America and are relevant because paramedical provision of injectables has been controversial in Africa. Based on this compelling evidence, an advocacy campaign was undertaken to create awareness of the impact of introducing injectables to existing CBD programs in Africa.

Methodology

An advocacy campaign with global and country level elements was designed. At the global level, the campaign’s main objective was to generate interest from other countries on the continent to introduce the practice. At the local level, a Uganda-specific specific advocacy strategy was developed to 1) review policy and guidelines to include provision of Depo-Provera by trained paraprofessionals, 2) encourage allocation of resources for the initiative in other districts, and 3) build awareness and support among stakeholders. This local advocacy campaign included: convening an advisory team, holding sensitization meetings, presenting on evidence-based policy recommendations and utilizing local experts and advocates. These local-level activities complemented global-level activities such as South-to-South educational tours for potential new partners, and tool development, including the creation of an advocacy kit and an implementation handbook. Additionally, a global online e-forum on CBD of injectables, hosted in collaboration with Management Sciences for Health, was held and attended by 331 participants from 19 countries.

Findings

The advocacy campaign is one element contributing to the global momentum of expanding CBD of Depo-Provera in the past three years. Since the start of the advocacy campaign, more countries have begun implementing, or become interested in the intervention. CBD of Depo-Provera has been scaled up into six new districts within Uganda; Madagascar’s Ministry of Health and Family Planning has called for national scale up; and Nigeria, Kenya, and Zambia will be conducting demonstration projects in 2009. Additionally, more than 4,000 advocacy kits and nearly 2,000 implementation handbooks have been disseminated. The work of...
other USAID-supported cooperating agencies, such as Health Policy Initiative (HPI), has also contributed to global momentum by providing policy-level assistance to interested countries. For example, Malawi redrafted its policies to support CBD of Depo-Provera during this period with HPI’s assistance.

Advocacy can be an effective way to promote a controversial family planning innovation. A primary result from these efforts was the commitment from Kenya, Nigeria, and Zambia to launch a demonstration projects. Moreover, local scale-up within Uganda continues as more advocacy activities are planned to reach out to additional districts within the country. Given that injectables are a preferred method and that community health programs serve a broad sector of the population, the introduction of injectables through this distribution system has the potential to substantially increase contraceptive prevalence.

Lessons Learned

Advocacy efforts can affect access to contraceptive services if they include: 1) a defined strategy to effect change, 2) commitment by lead health actors in reproductive health at the country level, 3) targeted sensitization of stakeholders, including those groups resisting the innovation and those ready to try it, 4) donor support and partnerships to sustain momentum, and 5) support from advocates of the innovation.

A08: 4

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

Anne Jorgensen1, Ana Bhuyan2, Suneea Sharma3, Lucia Merino2, Gadde Narayana4, Himani Sethi4, Claudia Quinto5, Marisela de al Cruz2, Alexia Alvarado5, Fernando Cano1, Imelda Zosa-Feranil2

1Futures Group International/Health Policy Initiative, Task Order 1, United States of America; 2Centre for Development and Population Activities (CEDPA)/Health Policy Initiative, Task Order 1; 3Futures Group International, Guatemala; 4Futures Group India; 5Futures Group International, El Salvador; abhuyan@futuresgroup.com

1. BACKGROUND/SIGNIFICANCE: A supportive policy environment provides the foundation on which to build equitable, sustainable health programs. Lack of proper attention to policies often leads to services that are ineffective, inappropriate, or ill-planned. Good policies are important, yet they are not sufficient. Policies must be put into practice. Doing so requires strong leadership, clear operational guidelines, effective institutional arrangements, and strategic planning and resource allocation. Experience shows that use of sound evidence and meaningful involvement of various stakeholders improve policies and facilitate implementation.

In recent years, family planning and reproductive health (FP/RH) policies and programs have had to contend with waning resources and lack of high-level commitment as countries grapple with a range of health and development challenges. User-friendly tools and approaches are needed to help FP/RH advocates and program managers ensure that FP/RH policy issues stay atop policymakers’ agendas.

2. PROGRAM INTERVENTION/ACTIVITY TESTED: The USAID Health Policy Initiative, Task Order 1, designed the Policy Implementation Assessment Tool (PIAT) to assess the nature and extent of policy implementation. The objectives of the tool are to: (1) identify barriers and facilitators of policy implementation; (2) foster multisectoral dialogue on potential solutions; and (3) promote accountability for and renewed commitment to policies. To pilot the approach, multisectoral, in-country teams have adapted and used PIAT to assess implementation of the RH component of Guatemala’s Social Development and Population Policy and the State Health and Population Policy for Uttarakhand, India.

3. METHODOLOGY: PIAT is designed to be tailored to the country context and specific policy. The tool comprises two questionnaires (for policymakers and implementers/other stakeholders) that consider seven dimensions: (1) The policy, its formulation, and dissemination; (2) Social, political, and economic context; (3) Leadership; (4) Stakeholder involvement; (5) Planning and resource mobilization; (6) Operations and services; and (7) Feedback on progress and results. The tool enables stakeholders to gather information about a multifaceted process in a systematic, user-friendly manner. With this evidence, they can better understand what is and is not working, explore root causes, and begin to devise solutions to identified barriers.

Application of the tool is led by an in-country core team that includes the major FP/RH stakeholders in the country, including the government, civil society, and donor community. The Assessment in Guatemala (2007) included in-depth interviews with seven policymakers and 29 program implementers. In Uttarakhand (2008), the assessment included 36 interviews with state- and district-level policymakers and implementers. The team also adapted the questionnaires to create focus group discussion (FGD) guides for use with 16 FGDs with 80 community-level functionaries, and 16 FGDs with 128 clients, including women and men from rural and urban areas and from scheduled castes.

4. FINDINGS: The assessments identified facilitators and several barriers to FP/RH policy implementation. In both cases, stakeholders re-confirmed the importance of the policies and identified decentralization as helping to put policies into practice. Some common barriers included the need for ensuring proper dissemination and training on the policies so that they guide service delivery; creating clear mechanisms and guidelines on accessing and using FP/RH funds; and improving coordination across different sectors, among others.

Most important, in both cases, the tool and subsequent policy dialogue have catalyzed action. In March 2008, Guatemala’s Congress created a national board to monitor RH policy implementation and advocate for increased funding. As of early 2009, stakeholders in Uttarakhand are revising the state’s policy based on the PIAT assessment, the latest health data, and results of innovative RH interventions.

5. KNOWLEDGE CONTRIBUTION/LESSONS LEARNED: PIAT provides a qualitative methodology to engage stakeholders in efforts to renew commitment to FP/RH through support for improved policy implementation. Application of the tool has proved to be straightforward, relatively inexpensive, and participatory.

Lessons learned include:

• The value of local stakeholder involvement, which helped build credibility and buy-in for the activities.
• The need to explore crosscutting issues, such as gender inequality and poverty.
• The importance of multisectoral dissemination and discussion of findings, which can re-focus attention on the policy and create a forum for stakeholders to discuss recommendations for improving implementation of the policy.
• The need for resources to support follow-up work on the identification and adoption of proposed solutions is the crucial next step in the process.

A guide on using the tool, including the questionnaires and data collection spreadsheets, is available. Guidance on adding supplementary issues (gender and poverty) and creating FGD guides is also available. Ultimately, it is hoped that the tool, guide, and lessons learned will assist government and civil society advocates to develop a better understanding of the extent and form of policy implementation. With this information, they will be better able to identify recommendations for translating FP/RH policies into action. In addition, the tool is flexible and can be applied to other health issues. It has been used to assess implementation of national HIV policies and plans in Guatemala and El Salvador.

A08: 5

Implementing Sustainable Solutions to Enhance Access to Family Planning among the Poor in Kenya
1. Background/Significance: Non-availability of family planning /reproductive health (FP/RH) services for the poor is strongly correlated with a heavy health burden, large economic loss, and unacceptable inequality in income and economic opportunities. Having many children can mean fewer resources (money, time, and attention) invested in each child, leading to poor nutrition, ill health, and limited educational opportunities and, ultimately, tying the poor to the poverty trap.

2. Program (Intervention/activity tested): The USAID Health Policy Initiative, Task Order 1, in collaboration with Kenya’s Health Care Financing Strategy Task Force and Division of Reproductive Health in the Ministry of Public Health and Sanitation worked to enhance the development and implementation of strategies for improving access to FP and RH services among the poor. This involved collaboratively identifying and addressing barriers to FP access; reviewing and revising existing policies/strategies; and designing appropriate indicators to monitor the impact of pro-poor interventions in Kenya.

3. Methodology: The project conducted market segmentation, system diagnosis, and operational barriers analyses followed by a rapid assessment of barriers to FP access among the urban and rural poor in Nyanza Province. The study considered the urban poor (Kaloleni/Kisumu), rural poor (Kombewa/Kisumu West), Wagai Division (Siaya district) and Macalder (Migori). Focus group discussions were also held with: women FP users and non-users under age 30, women FP users and non-users over age 30, and men. In-depth interviews were administered to service providers and exit interviews conducted with FP clients in six public health facilities and, three non-public health facilities. To promote policy dialogue, we shared the findings and their implications and allowed the poor, policymakers, community members, and other stakeholders to brainstorm on strategies that can be used to change the situation. Participants in the dialogue included FP users and non-users, men, church and mosque leaders, community-based distributors, community health workers, health service providers, provincial RH stakeholders, government, NGOs, and USAID cooperating agencies. In particular, the poor, their representatives, and other community members were given an opportunity to present the barriers they face directly to policymakers.

4. Findings: The assessment identified several barriers that impede access to FP services among the poor. These include: (1) Lack of male involvement: There is hardly any communication about FP between spouses. More often, women secretly use contraceptives without men’s knowledge—their plight only known when they develop complications. High prevalence of covert use of contraceptives is especially high in the study area because of fear of reprisals from spouses, occasionally leading to domestic and sexual violence. (2) Religious barriers, based on the premise that “God forbids the use of contraception.” (3) Frequent contraceptives commodities stock outs in government facilities due to systems failures including weak planning, budgeting, and priority setting. (4) High costs of accessing FP services in terms of long waiting time, transportation, and wage loss. The exemptions policy for the provision of maternal and child health services (including FP) in government facilities notwithstanding, clients pay Ksh. 20/- to Ksh. 500/- for FP services in terms of fees for registration/access, commodities, supplies fees, and staff motivation fees. (5) Misinformation and misconceptions relating to the adverse aspects, such as birth defects and developing complications as a result of side effects.

5. Lessons learned: To address the complex issues of ensuring access to family planning and to implement sustainable solutions, the project identified appropriate policy interventions at national and provincial levels. The development and implementation of these interventions involved several interwoven processes: awareness-raising among a broad range of stakeholders at all levels, building partnerships and support, tapping into multisectoral planning groups, building local capacity, mobilizing information for decisionmaking, and updating pro-poor monitoring and evaluation indicators. The following pro-poor strategies were selected and implemented to address the identified problems: (1) incorporating equity goals, pro-poor strategies, and equity-based monitoring and evaluation activities into the National Reproductive Health Strategy; (2) conducting high-level policy advocacy with Parliamentarians to gain commitment for improving access to FP among the poor and mobilize resources for FP; (3) designing a targeted approach to improve FP access in selected regions and urban poverty pockets; (4) informing the design of health sector financing strategy to ensure financing for services for the poor; and (5) promoting representation of poor in various planning and program committees.

B08: Operations Research on Postpartum FP

Time: Tuesday, 17 November 2009: 4:00pm - 5:30pm
• Given the poor quality of and low attendance at clinics for postpartum care, what strategies can effectively encourage women to attend for services at clinics? Can the number of postpartum care consultations be increased? And for those that attend, how can postpartum FP be effectively integrated into the maternal (and infant) health services?

• What adjustments need to be made to existing treatment, care and support services so that postpartum HIV-positive women can receive appropriate counseling and FP services?

Methodology
This paper draws from a review of the published and unpublished literature on research into clinic-based FP services. Data and findings are reviewed from over 50 studies conducted in Africa, Asia, Latin America and the Caribbean. A large proportion of the studies are evaluations of service delivery interventions using quasi-experimental or true experimental designs. Only studies that systematically collected data with a sufficiently rigorous study design are included.

Data and findings
Results from the papers reviewed are organized according to the research questions listed above. Evidence of the effectiveness of providing information about FP during antenatal care on postpartum use is mixed and seems to depend on ensuring the woman also attends for postpartum care. Male involvement produces positive health outcomes, but ensuring their active and appropriate engagement can be problematic. Immediate post-delivery provision of FP information and contraceptive methods is clearly effective in enhancing postpartum FP use, although some challenges to doing this in hospitals and maternities are raised. In principle, the use of LAM for a short period when a woman resumes sexual activity can be effective, but distinguishing between counseling for breastfeeding and for LAM seems problematic in clinic-based settings. Integrating FP services into the traditional six-week (40 day) postpartum consultation is feasible and effective, although using outreach or community-based visits at this time can help reach underserved populations. Data on the delivery of FP services to, and their use by, HIV-positive women following delivery are surprisingly rare and so it is difficult to draw evidence-based conclusions at this point in time.

Knowledge contribution
This paper summarizes the latest research-based evidence concerning the provision of FP information and services to women in the postpartum period and organizes the findings to address issues that face program managers and policymakers in virtually all developing countries. Although efforts are made to draft generalizable recommendations to guide programming, the importance of national context cannot be over-emphasized, given the wide variation in sociocultural norms concerning reproductive health and sexual behavior in the postpartum period and the variability in resources available to both FP and MNCH programs. Gaps in understanding are identified and suggestions made as to the research needed to address these.

B08: 2
Increasing use of LAM and postpartum contraception through a community-based intervention among low parity women in Uttar Pradesh, India

M.E. Khan, Mary Sebastian
Population Council, India; cwarren@popcouncil.org

Background
The Family Welfare program of the Government of India has successfully increased contraceptive use, and especially permanent and long-acting methods, among couples who have achieved their desired family size. However, the needs of low parity women who want more children to have access to and use temporary family planning (FP methods during the extended postpartum period to increase spacing of subsequent birth(s) have not been sufficiently addressed. This study tested the feasibility and effectiveness of using a community-based behavior change communication (BCC) intervention to educate women and their families about the health and birth spacing effects of using the Lactational Amenorrhea Method (LAM) and postpartum contraception among pregnant women to space next birth.

Intervention tested
Based on the findings of formative research, simple, unambiguous messages about the risks of early- and closely-spaced pregnancies and the benefits of maintaining at least a 3-year interval between births were developed and an educational campaign developed to communicate them. The campaign was implemented by 267 community health workers (CHWs) already working in the Indian health program, who were first oriented in antenatal and postnatal care and in LAM and FP methods and then trained (through lectures and role-play) in counseling skills and the use of educational booklets to specifically address young couples’ reproductive health needs. A ‘work register’ was given to CHWs to help them to systematically cover all relevant topics during counseling. After counseling during home visits, women were given a copy of the booklet, with instructions to share it with their husband and mother-in-law. Group meetings were organized at community centers for pregnant women, older women, husbands and community elders.

Methodology
The study used a quasi-experimental pre-post control group design and was conducted in 48 villages of Meerut district, with 24 villages each in the experimental and control groups. Each study group recruited 600 women at 3-6 months gestation, with a parity of 0 or 1. Women were interviewed on recruitment and at four months and nine months postpartum. In addition, their husbands and mothers-in-law were interviewed at recruitment and nine months postpartum.

A baseline survey and formative research preceded the intervention. Formative research consisted of focus group discussions with newly-married first-time-parents, mothers-in-law, community leaders, and CHW besides 30 in-depth interviews of newly married, first-time-parents.

Data and findings
Significantly more women in the experimental than control areas reported receiving counseling on postpartum care and contraception.

In the experimental areas, 88% of women had received the educational booklet and read it; of these, 89% had shared it with their husband and 49% with their mother-in-law. Husband—wife communication on postpartum FP and planning for the next child increased.

Knowledge of modern spacing methods and their use increased significantly in the experimental areas compared to the control areas, among both women and men.

Use of modern contraceptive methods and LAM significantly increased in the experimental areas. At nine-months postpartum, 62% of women in experimental sites were using a modern contraceptive and 22% had used LAM, compared to 31% and 0% respectively in the control areas. The condom was the
method used most frequently (44% in the experimental area and 23% in the control area). Of the 22% of women who used LAM in the experimental area, over two-thirds (68%) transitioned to a modern contraceptive.

Logistic regression analysis revealed that women’s education, knowledge of FP methods, survival of the index child and husband-wife communication were the key covariates of postpartum FP use, with large odd ratios values.

Lessons learned
1. Young couples do want to delay their next pregnancy and will use postpartum FP if a well-planned and implemented communication strategy is implemented.
2. The BCC model developed is effective at the community level and can be easily implemented in other settings.
3. Messages need to be appropriately designed for and communicated to different audiences as not all messages are equally appealing. While most women, families and community members support spacing the following pregnancy, their reasons may vary.
4. Misconceptions about the return of fertility and its links to the biological marker of menstruation are the main barriers to timely initiation of postpartum contraception.
5. Acceptance of CHW visits to a family increases if their counseling focuses on birth spacing and its benefits for the mother, child and the family.
6. Technical assistance and capacity building of the existing cadres of CHWs in the health system is feasible, enabling this intervention to become sustainable and be scaled up and replicated elsewhere.

B08: 3

**Strengthening postpartum family planning services to increase use of contraception in rural Egypt**

*Nahla Abdel-Tawab*

Population Council, Egypt; cwarren@popcouncil.org

**Background**

A major challenge facing policy-makers in Egypt is how to support low-parity women to delay their next pregnancy for at least two years though increased use of family planning (FP) during the postpartum period. About half of all births in Egypt occur less than three years from a previous birth, but many women do not use postpartum FP for several reasons: they, their husbands or their families are not aware of the health risks of short birth intervals; they rely on breastfeeding without observing the three criteria for the Lactational Amenorrhea Method (LAM) or without transitioning to a contraceptive method; or they lack correct information about FP methods and their use postpartum, especially about side-effects. To respond to these challenges, an operations research study was undertaken to determine the feasibility, acceptability and effectiveness of two versions of a behavior change communication (BCC) model that sought to increase postpartum use of FP.

**Intervention tested**

For Model I, additional messages were communicated through existing health services provided by health workers to women during antenatal and postpartum consultations. Model II provided these same services and information plus an additional community-level awareness-raising component that targeted men with appropriate messages through training community influencers to communicate information about postpartum FP and birth spacing to their peers.

**Methodology**

The study used an experimental design in six health districts, three from each governorate of Assiut and Sohag in Upper Egypt. One district in each governorate was randomly assigned to implement Model I, Model II or to serve as a control site by providing standard care only. Sources of data included: (1) exit and home interviews with low parity pregnant women at 4 months and 10-11 months postpartum (a total of 1,416 women); (2) structured interviews with physicians, nurses and family planning outreach workers; (3) in-depth interviews with local Ministry of Health and Population managers and supervisors; (4) focus group discussions (FGDs) with community influencers; (5) FGDs with husbands of low parity women; and (6) service statistics on utilization of MCH and family planning services.

**Data and findings**

Providing birth spacing messages to low parity women during antenatal and postpartum care and also to husbands through community awareness activities was feasible and acceptable. Both models proved effective in changing women’s knowledge and attitudes towards birth spacing and in enhancing use of contraception at 10-11 months postpartum, by 48% among Model I mothers and 43% among Model II mothers, compared with 31% among control group mothers. Over the postpartum period, women in the two intervention groups used contraception more consistently than women in the control group – median duration of protection against pregnancy was 6.8 months for Model I mothers, 4.5 months for Model II mothers and 2.9 months for control group mothers). Both intervention models were associated with an increased utilization of services, especially FP services, by women who only had one child (36% increase in Model I clinics, 47% increase in Model II clinics and 3% increase in control clinics). A fear of contraceptive side-effects continues to be a major concern among women and men in all groups and is an obstacle in achieving healthy birth intervals.

Lessons learned

Messages on postpartum FP and birth spacing should be an integral component of antenatal care services for low parity women. The standard protocol for postpartum home visits should be revised to include fewer and more effective visits by the MCH nurse and Community Health Worker to promote use of LAM and postpartum FP in addition to messages about breastfeeding, personal hygiene and nutrition. Their roles and messages should be clearly defined to avoid duplication. Services provided for the mother on the standard 40th day visit should be combined with well-baby services for the newborn to enhance use of both services and improve efficiency. Health providers should receive adequate training on the management of side-effects and clients who receive FP methods should be given information about possible side-effects that can also be shared with concerned members of their families; community-level mechanisms to help women deal with side-effects should be instigated. The effectiveness of community seminars was weak but could be enhanced by selecting strong male role models and embedding FP messages within the broader context of family health.

The results have been widely disseminated in the two study governorates and nationally. National service delivery guidelines for antenatal and postpartum care have been amended to include messages about postpartum FP; the national training curriculum and clinical guidelines for postpartum (and postabortion) FP have been revised; a pool of master trainers has been trained to decentralize cascade training in the revised services; and IEC materials have been produced and widely disseminated. In addition to this capacity-building at the national level, the model is currently being scaled up within the two governorates.

B08: 4

**Postpartum family planning in a high HIV environment: evidence and challenges**

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Improving Social Marketing of Female Condom in Nigeria: Expanding level of coverage and quality of coverage

Samson Babatunde Adebayo, Richard Fakolade, Victoria Archibong, Jamilah Mohammed-Jantabo

Society for Family Health, Nigeria; sadebayo@sfhnigeria.org

Background

Although female condom was first distributed in Nigeria in the 90s, the knowledge about and uptake of the product has remained abysmally low among men and women according to findings from national population-based household survey on HIV/AIDS and reproductive health in Nigeria. The low uptake of this product is attributed to numerous factors such as social, cultural, economic and programmatic challenges. Therefore, a social marketing approach to improve knowledge and availability of female condom which in turn enhances usage is desirable.

Activity tested

This paper assessed the coverage and quality of coverage of female condom in Nigeria through measuring, access and performance survey

Methodology

Measuring Access and Performance (MAP) survey aimed at estimating level of coverage and quality of coverage for female condom, based on some predetermined standards. The use of lot quality assurance sampling (LQAS) technique was employed to elicit information on level and quality of coverage for

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female condom in the Universal Access for Female Condom (UAFC) focal states of Delta, Edo, and Lagos. For the study, nineteen (19) localities selected through a probability proportional to size technique in each of Edo, Delta and Lagos states resulting in a total of 57 localities. These localities were first ordered based on the geographical locations on the map of Nigeria before selection was done. Lists of localities were provided by the National Population Commission (NPC). Simple audit sheets were used to collect information on coverage and quality of coverage from the outlets in the selected 57 localities from the three states. The audit sheets were developed based on the information needed for calculating level and quality of coverage.

Data
Data collected through the audit sheets were processed in SPSS. During analysis, variables for coverage and quality of coverage were constructed. Inference was based on Lot Quality Assurance Sampling (LQAS) decision rule.

Findings
Results revealed that coverage of the product was generally low in these states, with Delta having a relatively higher coverage than Lagos and Edo. For instance, coverage was 55% in Delta state compared with 45% and 35% in Lagos and Edo states respectively. Similarly, quality of coverage was also low as illustrated by lack of promotional materials in all the outlets visited coupled with stock-outs. Furthermore, results revealed low penetration of the product in each of the three states. This supports the piece of evidence that coverage level of the product was poor across the states.

Lessons learnt
Measuring Access and Performance will guide program design and implementation by facilitating the establishment of functioning distribution and delivery system from state to community level. It will also help in improving quantity, quality and efficiency of distribution outlets for female condoms. On the whole, there is need to improve on coverage and the quality of coverage indicators for this product in the focal states. This can be done by making the product widely available through the development, production and deployment of promotional materials, to create and sustain public awareness and knowledge. This can facilitate patronage for the product and further help to mitigate the incidence of stock-outs which may ultimately yield into positive health outcomes.

CO8: 2
Increasing Availability of Intrauterine Contraceptive Device Within A Social Franchised Network Through Use Of Reproductive Health Days
Jayne Rowan1, Nyo Nyo Minn1, Dan Rosen2
1PSI/Myanmar, Myanmar; 2PSI; jrowan@psimyanmar.org

Background
PSI/Myanmar provides reproductive health products and services to low income communities through the Sun Quality Health (SQH) social franchise network of private doctors. SQH members are licensed general practitioners (GPs) with pre-existing clinics serving low-income populations, who work full-time in their clinics and who demonstrate a positive attitude towards quality and equity in health care. The Sun doctor receives training in reproductive health and contraceptive commodities at highly subsidised prices in return for providing agreed quality standards to the client.

Between the periods 2003-2007, PSI/Myanmar trained 104 doctors on the intra-uterine contraceptive device (IUCD). However insertions for the same period remained static at approximately 200 per year. Operational research conducted in February 2008 revealed that the majority of providers had stopped offering IUCD and that actual availability of long term contraceptive methods for women was low.

Intervention/Activity
Reproductive health events increase the availability of IUCD, aimed at low income women living within a selected radius of a SQH clinic. The events are attended by a PSI/Myanmar team of three doctors who are trained in IUCD so that a full range of methods can be offered at the clinic thus expanding contraceptive choice for women.

Methodology
Reproductive health SQH sites are selected by PSI/Myanmar using the following criteria: the SQH provider has received PSI/Myanmar IUCD training; willingness to host an event; and SQH provider prepared to conduct IUCD follow up consultations.

Reproductive health events are promoted through the use of community organisers who inform women that they can receive reproductive health counselling and contraceptive method of their choice on the advised dates. Community organisers promote the events within a defined catchment area which is set a maximum of three hours travelling time.

On the event day PSI/Myanmar sends a team consisting of three IUCD trained doctors to the designated clinic. On arrival the team sets up the clinic for best practices which includes infection prevention measures.

When the event commences one doctor is responsible for reproductive health counselling and short term method provision. Those requesting the IUCD at the end of the counselling are referred to the other two doctors who conduct eligibility screening. Women found to be non-eligible or decide against an IUCD after screening are offered alternative methods of their choice. Those eligible and want to proceed are inserted with an IUCD which is followed by observation in the clinic for fifteen minutes. Following the observation period women not showing any warning signs are given post insertion counselling and a one month follow up appointment date. The one month follow up consultations are either conducted by Sun providers during regular clinic hours or at further events as appropriate.

The reproductive health events are also used by PSI/Myanmar to give the Sun provider supportive IUCD training. This includes observation and clinical practice on counselling techniques and IUCD insertions and removals.

The reproductive health days are monitored by a Quality Assurance Manager who routinely attends events to evaluate the quality of care delivered and to ensure compliance against PSI/Myanmar service delivery protocols.

Data
A total of 11,570 IUCDs have been inserted by six PSI/Myanmar IUCD teams at 214 reproductive health events for the period July 2008 – April 2009.

IUCD insertions have also increased at SQH clinics during regular hours (non-reproductive health events). A total of 5,938 IUCDs were inserted in SQH clinics for the period July 2008-April 2009, as compared to 200 in 2007, an increase of 1366%.

The number of women attending follow up appointments from both reproductive health events and regular Sun clinic days is 15% of insertions and there have been 17 reported removals. PSI/Myanmar has anecdotal evidence after operational research with Sun providers that the actual removal rate is approximately 8%.
Findings

Reproductive health events and the use of PSI/Myanmar IUCD teams have been successful in increasing the availability of long term methods at SQH clinics.

Lessons Learned

Utilising existing clinics within the social franchise network to conduct events has meant that PSI/Myanmar has expanded IUCD access whilst also providing on-site supportive training which builds providers skills and confidence to offer IUCDs during regular clinic hours.

COB: 3

Total Market Approach to Improving Family Planning Access in the Republic of Georgia

Nino Berdzuli¹, Nancy Harris¹, Kartlos Kankadze²

¹John Snow, Inc, United States of America; ²John Snow, Inc, United States of America; ¹Healthy Women in Georgia Program, JSI Research & Training Institute; nberdzuli@jsi.com

Background/Significance: In Georgia, as in most of the former Soviet Union, widespread reliance on abortion to regulate fertility, lingering distrust of modern family planning methods (particularly hormonal methods) has resulted in some of the world’s highest abortion rates and very low contraceptive prevalence rates (CPR). Low CPR also is a result of deficiencies in access to family planning services, especially in rural areas and small towns and in lack of information about family planning among ordinary people and family doctors. Previously, legal restrictions meant only specialist gynecologists provided services and they worked only in urban areas. Finally, family planning was not supplied through state-funded health services, and subsidized donor-funded contraceptives were only available in urban areas. An ability-to-pay survey conducted in 2004 noted that only expensive commercial brands were available in most pharmacies, leaving bottom 40% of income earners unable to afford contraceptives.

Intervention/Activity Tested: The Total Market Approach (TMA) strives to create a balance between the private and public sector product and service availability and to utilize their respective capabilities to achieve public health goals—in this case broad geographic and socio-economic access to family planning services. The USAID-funded JSI Healthy Women in Georgia Project (HWG) used the TMA on a national scale in Georgia to address the needs of underserved populations, target contraceptive subsidies more effectively and grow overall demand for family planning products and services using an innovative and successful public-private partnership model.

Methodology: In 2004, the JSI HWG project began family planning interventions in two regions of Georgia. By 2009, the program had scaled up to all six regions of the country. To improve access to family planning services, JSI HWG worked with the Ministry of Labor, Health and Social Affairs (MoLHSA) and other stakeholders to eliminate legal restrictions and family doctors and nurses to provide FP services and counseling in rural primary health care clinics. Over 1,000 providers were trained in evidence-based contraceptive medicine and modern counseling techniques to change provider attitudes toward modern contraception and provider concerns, especially about hormonal methods. Pharmacists also were updated on contraception, and contraceptives manufacturers and distributors were involved in the training. Within four years, the number of rural and peri-urban PHC sites providing family planning grew from virtually zero to over 500 sites.

JSI HWG used a market segmentation strategy to target provision of free US Government‐donated contraceptives to women and couples living in rural and poor urban areas. (In Georgia, virtually all rural families fall into the lowest quintiles in income.) HWG developed Georgia’s first comprehensive logistics management information system (LMIS) and worked with district public health authorities, which took responsibility for monitoring and distributing contraceptives.

To ensure a continuous supply of affordably priced commercial contraceptives, JSI HWG works with contraceptives distributors to make low cost products widely available. Increasingly, commercial suppliers are expanding their product lines to rural areas. JSI HWG began working with contraceptive distributors in 2004 and has developed formal working relationships, including agreements to train doctors but not supply free contraceptives in markets where couples can afford to pay for these products from commercial sources.

A social marketing media campaign was launched using the slogan “Contraception—Modern Choice” and involving both MoLHSA and commercial partners in designing the logos, television spots, billboards and educational materials. The campaign reached most of the country.

Findings: Family planning services are no longer offered only by gynecologists and urban areas. Over 500 primary health care sites now offer services to an increasing number of clients. This represents coverage of 60% of Georgia’s population. Use of modern contraceptives that originally had lower than the national average contraceptive prevalence rate, has increased in these sites, most of which serve women in great need—poor women living in rural, isolated communities, ethnic minorities or internally displaced persons (IDPs). To date, evidence suggests abortion rates are falling sharply.

Contraceptive available through commercial distributors and pharmacies has improved availability of low-cost products and brands in both rural and urban areas. The social marketing campaign generated gains in creating informed consumer. Market data from commercial distributors show a 13% increase in contraceptives market growth.

Lessons Learned: To achieve maximum impact and coverage in short time spans, and to expand to national scale, family planning programs need to be comprehensive, taking a long term view and using complementarily public and private sectors. This Total Market Approach utilized in Georgia proved to be sustainable model for improving access of family planning services, affordability of contraceptives and increasing the overall commercial market of contraceptives.

COB: 4

Experience of Oromia Development Associaiton on Cost Sharing

Mulugeta Hawas, Tessema Firdissa

Oromia Development Association, Ethiopia; oda-cbrh@ethionet.et

1. Background/Significance

Oromia is one of the largest regional states of Ethiopia with a population of 27,158,471 in 2007. It is about one third of the national population; characterized by high maternal mortality rate (MMR), Infant mortality rate (IMR), Child mortality rate (CMR) and very low contraceptive prevalence rate (CPR) 15% (DHS 2005). Oromia Development Association introduced and run an integrated community based reproductive health family planning program (CBRH/FP) with service charge covering 95 Woredas out of 274 in the region for nine years. The purpose of CBRH model with service charge is to expand services to underserved rural communities (health service coverage was about 35%, OHB when the project started), to increase range of contraceptive options through procuring contraceptives and to ensure continuity of service. The project is implemented with 3,000 voluntary community health agents.

2. Research: State main question/hypothesis
How does contraceptive supply will be best ensured?

3. Methodology (including location, setting, period, analysis approach)

The communities were consulted to make informed decisions on the use of contraceptives and on the amount of service charge they have to pay. Based on the consultation with the community it was agreed to introduce service charge to ensure contraceptive supply. The meeting further decided the amount to be charged for a cycle of pills, a vial of Depo-Provera, and set of Implant (Norplant) and procedure of IUCDs. Accordingly, a cycle of pills was charged 1 Birr, Depo-Provera 3 Birr and 10 birr for Implant (Norplant) & IUCD. Service charge is based on what clients can pay or are already paying for services they are receiving from community based reproductive health agents (CBRHA). And, ability to pay is determined based on discussion with community representatives and experience from the private sector. For those who cannot pay-referral is given to the near by health facility where they can get for free. If the health facility is far from CBRHA service delivery point and the client is very poor, couples are provided for free. The second option for those who are very poor and have viable project ideas is that they are linked to micro finance institution. We also observed by dividing the project sites in to two; where clients in five of the woredas were asked to pay 50% less to what the project has agreed to charge clients by methods and compared with other five woredas of the batch who are paying the amount the project has decided in consultation with the community. Sixty percent of the money collected is paid back for CBRHA and the 40% is deposited in block account to use it as a revolving fund to procure contraceptives whenever there are shortages and to continue service provision when the project phases out.

4. Data (if relevant)

5. Findings

The approach has significantly improved in creating the awareness of the target population on issues revolving around reproductive health/family planning and development. In an assessment of community based reproductive health services in Ethiopia, 2002-2003, by Ministry of Health, it was found that in areas where CBRHA are working, 76% of the clients have reported that they know and they are willing to pay for the services provided to them by CBRHA, while it was about 81% for Oromia region & 90% in areas where ODA-CBRH program was operating.

The other finding from our service statistics data was that, the number of clients could not increase as a result of the price reduction made, even in some project sites the number of clients has decreased over time indicating that communities are willing to pay and valued the services they are receiving. More than 98% of 900,000 Clients have been paying for the services they are receiving from CBRHA and more than 10 million Birr was collected of which 40% is used as a revolving fund.

As a result of the service charge the project was able to motivate community health agents to avail more of their time to render free services for their community. The money collected was used as a revolving fund to procure contraceptives through social marketing to increase the range of contraceptive choices and to become less reliant on donors.

CBRHA associations have been established and making use of the money collected as revolving fund for income generating activities and has continued to serve their communities after the project has closed out.

6. Research: State knowledge contribution

Program: State lessons learned

In countries with low health service coverage CBRHA model has been proved as the most successful approach to mobilize resources from communities and to increase contraceptive uptake. Clients who pay fee for service are more likely to value the services they receive and demand high quality services. Advocacy for service charge and enhancing voluntary CBRH model approaches should be encouraged as part of ensuring contraceptive security efforts.

D08: Addressing the FP Needs of People Living with HIV II

Time: Tuesday, 17 November 2009: 4:00pm - 5:30pm

D08: 1

Effect of hormonal contraceptive use on time-to-death in female incident HIV seroconverters in Rakai, Uganda

Chelsea Bernhardt Polis 1, Ron H Gray 2, Tom Lutalo 3, Fred Nalugoda 4, David Serwadda 1, Godfrey Kigozi 2, Joseph Kagaayi 2, Noah Kiwanuka 3, Nelson Sewankambo 2, Michael Z. Chen 1, Maria Wawer 1

1 Johns Hopkins Bloomberg School of Public Health, United States of America; 2 Rakai Health Sciences Program, Uganda Virus Research Institute, Entebbe, Uganda; 3 Institute of Public Health, Makerere University, Kampala, Uganda; cpolis@jhsph.edu

Background/Significance

For HIV-positive (HIV+) women who wish to prevent pregnancy, use of an effective, long-term contraceptive method carries benefits in addition to controlling fertility and reducing the demand for abortion - it helps reduce mother-to-child HIV transmission by preventing unintended pregnancies among HIV-infected women. However, one randomized controlled trial suggested that hormonal contraceptive (HC) use increased the hazard of AIDS or death when used by HIV+ women. Efforts to promote use of HC among HIV+ women must be balanced against potential concerns that these methods could adversely affect their health.

Hypothesis or Intervention/Activity Tested

The purpose of our study was to assess the association between HC use and time to death among women with a known date of HIV infection in a Ugandan cohort study with over 13 years of follow-up.

Methodology

We conducted multivariate Cox regression analyses to assess the effect of HC use on time from HIV seroconversion to death, incorporating time-varying exposure information. We performed several sensitivity analyses, including using a lagged HC exposure variable, utilizing various comparison groups to explore different clinical questions, censoring women at the time of antiretroviral therapy (ART) availability, and separately assessing effects of oral contraceptive pills and injectables.

Data

We used data collected as part of the population-based Rakai Community Cohort Study in Uganda, spanning from 1994 until 2006. This study contained the largest sample of incident seroconverters ever analyzed for this purpose (N=625).
Findings

Time-varying use of HC (as compared with use of no method or a non-hormonal method) was not associated with increased hazards of death (adjusted HR: 0.72, 95% CI: 0.39-1.32, p=0.293). None of the analyses suggested an adverse effect of HC on HIV progression to death, including a lagged exposure analysis, an analysis censoring women at time of ART availability, utilizing various comparison groups, or the analysis of individual methods.

Knowledge Contribution or Lessons Learned

Our analyses suggest that HC was not associated with an increased risk of death in HIV+ women and thus does not support the concern that HC accelerates time-to-death among HIV-infected women. Clinicians’ ability to provide appropriate contraceptive counseling to HIV+ women has been hindered by our lack of understanding about the safety of hormonal methods in HIV+ women. Promotion of effective family planning methods is a crucial component of reducing mother-to-child HIV transmission, and given the high level of unmet need for contraception among HIV+ women, efforts to further integrate HIV services with provision of effective methods of family planning are urgently needed.

D08: 2

Predictors of Pregnancy in Microbicide Trials

Vera Halpern,1 Che-Chin Lie,1 Fernand Guédou,2 Florence Mirembe3, Christine Mauck1, Roshini Govinden5, Donna McCarragher2, Orikomaba Obunge4,

Folasade Ogunsola7

1Family Health International, United States of America; 2Unité de Recherche en Santé des Populations, Centre Hospitalier Affilié Universitaire de Québec, Québec, Canada; 3Makerere University, Kampala, Uganda; 4CONRAD, Eastern Virginia Medical School, Arlington, VA USA; 5HIV Prevention Research Unit, Medical Research Council, Durban, South Africa; 6University of Port Harcourt Teaching Hospital, Port Harcourt, Nigeria; 7College of Medicine, University of Lagos, Lagos, Nigeria; vhalpern@fhi.org

1. Background/Significance

Because of concerns about unknown fetal effects of investigational drugs, most HIV prevention trials attempt to exclude women who are planning to become pregnant and require women to discontinue product use if they become pregnant during follow-up. The time off product due to pregnancy reduces the power to detect the effect of the intervention. Therefore, high pregnancy rates in HIV prevention trials can sabotage these expensive studies and, more importantly, jeopardize the welfare of study participants and their babies. Hence, preventing unintended pregnancy in such trials is important.

One approach to achieving low pregnancy rates in an HIV-prevention trial would be to detect, prior to enrollment, women who are at high risk of pregnancy and either exclude them from the trial or provide them with additional relevant contraceptive counseling. Data from completed microbicide trials may help identify these women.

2. Research: State main question/hypothesis

We evaluated and summarized the relationships between participants’ characteristics and the incidence rates of pregnancy in four microbicide trials (SAVVY/Nigeria, SAVVY/Ghana, CS/Nigeria and CS/Multi-Country) in order to identify baseline factors associated with increased risk of pregnancy.

3. Methodology (including location, setting, period, analysis approach)

The effectiveness of two potential vaginal microbicide gels – C31G (SAVVY®) and 6% cellulose sulfate (CS) – was evaluated in four Phase III, double-blind, randomized, placebo-controlled trials conducted in Nigeria, Ghana, Benin, Uganda and South Africa between 2004 and 2007. The trials enrolled women who were HIV-seronegative, at high risk of HIV, non-pregnant, and reportedly not desiring to become pregnant for the duration of the study. Participants were randomized to use active or placebo gel along with condoms for all acts of sexual intercourse for 12 months. Participants were interviewed and tested for pregnancy at baseline and during monthly follow-up visits. We analyzed data from participants who contributed any follow-up pregnancy data. Cox proportional hazard models, stratified by site nested within study, were used to determine the baseline factors that predicted pregnancy. Only time to first pregnancy was included in the model. All models controlled for randomized treatment group and for the most effective contraceptive method used at baseline. Impacts of potential risk factors were assessed using a series of likelihood ratio tests to arrive at a parsimonious model.

4. Findings

A total of 6748 women contributed data for this analysis: 2082 in SAVVY/Nigeria, 2038 in SAVVY/Ghana, 1506 in CS/Nigeria, and 1122 in CS/Multi-country trial. Pregnancies were detected in a total of 1826 (27.1%) women in all four studies, including 552 (26.5%) in SAVVY/Nigeria, 769 (37.7%) in SAVVY/Ghana, 308 (20.5%) in CS/Nigeria, and 197 (17.6%) in CS/Multi-country trial.

Across the four studies, the hazard of pregnancy was higher for women who had history of pregnancy (HR 1.3, 95% CI 1.1-1.5); were living with a man (HR 1.2, 95% CI 1.02-1.4); or were engaged in trade or commerce compared to all other occupations (HR 1.1, 95% CI 1.01-1.3). The risk of pregnancy was lower among students (HR 0.8, 95% CI 0.7 - 0.99); women who at baseline reported using intrauterine contraception, implants or sterilization (HR 0.2, 95% CI 0.09 - 0.5); women who reported using injectables (HR 0.5, 95% CI 0.3 – 0.6); women who reported using condom during the last act of vaginal intercourse (HR 0.9, 95% CI 0.8 - 0.99); and women with more sexual partners in the last three months (HR 0.99, 95% CI 0.98 - 1.00). In addition, the risk of pregnancy was lower in older participants (for each one-year increase in age at screening, the hazard of pregnancy decreased by an estimated 10%).

Factors for which we found insufficient evidence of association with the risk of pregnancy included frequency of intercourse in the last week or in an average week, and self-reported use of oral contraceptives and condoms for pregnancy prevention at baseline.

5. Research: State knowledge contribution

Occupation in trade, cohabiting with a male sexual partner, and having been pregnant in the past put women at higher risk of becoming pregnant during the trial. Our findings also suggest that restricting enrollment to older women, women using condoms, and women with higher career goals (students) could help reduce pregnancy rates in the trial.

Future HIV-prevention trials could consider modifying admission criteria, but recruitment would be more difficult, and such modifications would exclude many women at high risk for HIV. An alternative would be to focus pregnancy prevention efforts on women who are likely to become pregnant. However, our data suggest that current use or acceptance of a first-tier contraceptive, such as IUDs, implants, or sterilization, is the most effective approach to reduce pregnancy rates and thus, might be a useful eligibility criterion for future HIV prevention trials. Effectively reducing pregnancy rates in HIV prevention trials would minimize potential risks of intrauterine exposure to an investigational drug and improve validity of the results.

D08: 3

Role of Menstruation in Contraceptive Choice Among HIV-Positive Women in Soweto, South Africa
Fatima Laher1, Catherine S. Todd1, Mark A. Stibich1, Rebecca Phoşa1, Xoliwa Behane1, Loreto Mohapi1, Glenda Gray1

1Perinatal HIV Research Unit, Witwatersrand University, South Africa; 2Columbia University, United States of America; 3Xenex Technologies, United States of America; cst2121@columbia.edu

Background: In South Africa, highly effective contraceptive methods are freely available through government sources and widely utilized, though the rate of consistent use over one year is 27.8%.1 Systemic injectable hormonal methods are the most popular, but also associated with high rates of discontinuation, largely due to bleeding pattern changes.2,3

HIV infection has been noted to affect menstruation.4 It is unclear whether HIV-positive women are more sensitive to menstrual changes, which inform contraceptive decision-making.

Hypothesis Tested: Perceptions towards menses and contraceptive-induced amenorrhea impact contraceptive discontinuation among HIV-positive women in Soweto, South Africa.

Methodology: This qualitative study was conducted at the Perinatal HIV Research Unit (PHRU), a clinical site located within Chris Hani Baragwanath Hospital. Eligible participants were HIV-infected women aged between 16 and 45 years; participants were purposively selected into three age groups: <22 years, 23-30 years, and >30 years.

Data: Participants completed a standardized questionnaire about HAART usage, fertility history, partnership status, fertility desires and contraceptive usage. Three focus groups (1/age group) were conducted to determine main themes, followed by 15 in-depth interviews to obtain further depth and explore themes. Transcripts were coded using a grounded theory approach and then grouped into themes. Coded quotations were also analyzed for impact of various demographic factors (such as parity) on themes (such as future fertility desire). Analysis was performed with ATLAS-ti (ATLAS-ti Center, Berlin).

Findings: There were 42 participants; these women had 1.90 mean pregnancies and 1.64 live births. Mean time since HIV diagnosis was 3.24 years, with 50% taking antiretroviral therapy (ART). Injectable contraception was utilized by 25 participants, of whom 24 had contraceptive amenorrhea. There was good agreement among the participants about menstruation and its meaning relative to HIV. Menstruation was seen as a way for “dirty blood” to leave the body. If menstruation did not occur (and the woman was not pregnant), it was believed illness would ensue.

"Menstruating indicates that I am alright. I am still alive and I am a woman. I don’t want to stop menstruating because this dirty blood needs to get out.” IDI 42, 20 years, 1 child.

Most participants reported no menstrual changes since HIV diagnosis. A few mentioned menstruation stopping because of going on the injection or had decreased in quantity spontaneously. No difference was noted between ART and non-ART taking participants. Women reported mixed feelings toward menstruation – it was something necessary for health, but they did not like the “dirtiness,” inconvenience and side effects of it. These perspectives changed with HIV diagnosis for some women, who became fearful of blood due to its symbolic reminder of infection.

Now, I don’t want to go on my periods, ever since being HIV positive. I am scared of (my) blood. When I see my blood, sometimes I vomit and other times I just feel sick. Other times I just start crying when I see blood. Before, when I was negative, I was fine, I never reacted like this to blood. IDI 35, 20 years, 1 child.

When specifically asked about injectable contraceptives, oligo/amenorrhea was a troublesome side-effect:

"Usually, when I am using Depo, I don’t menstruate, at all. But I know I’m not pregnant. I don’t feel good about this. I wish I could see my blood.” IDI 39, 35 years, 2 children.

However, some found this effect advantageous:

"I am just happy that I am not menstruating because I no longer have to worry about pads and period pains. Most of the time you are uncomfortable during your period, so I am really happy not to menstruate”. IDI 33, 25 years, 2 children.

Though not specifically asked, some participants offered that menstrual changes were the reason for discontinuation:

I was also on Nur-Isterate before I had my baby. It stopped me from having my period for 3 years. I went to the clinic to tell them about not having my period and they told me that there is nothing wrong. The only thing that I constantly asked myself was: Where is all this blood going to if it’s not going out of my vagina? After that I stopped using the injection. I thought that I should take a break. FGD 15, 27 years, 1 child.

Knowledge Contributions: In Soweto, perceptions about menstruation change with HIV diagnosis. However, equation of menstruation with health may be accentuated by diagnosis, leading to avoidance or discontinuation of methods causing amenorrhea. Further, these concerns may change over time or with other life events, like starting ART. Providers should discuss concerns surrounding menstrual changes and provide method choice at each encounter to ensure continuous contraceptive coverage.

References:

DDB: 4

Peri-conception pre-exposure prophylaxis for sero-discordant couples who choose to conceive children in resource-limited settings.

Lynn T. Matthews1, David R. Bangsberg2,4

1Beth Israel Deaconess Medical Center; Boston, MA; 2Harvard Initiative for Global Health; Boston, MA; 3Massachusetts General Hospital; Boston, MA; 4The Ragon Institute; Boston, MA; lmatthe@bidmc.harvard.edu

Background: As antiretroviral therapy restores health and increases life expectancy, couples affected by HIV face complicated choices between fulfilling reproductive desire and risking HIV transmission to their partners and children.

In the sub-Saharan African epidemic where incident infections disproportionately affect young women of child-bearing age, the frequency with which HIV transmission results from unprotected sex and desire for children is unclear. Traditionally, HIV-affected couples are advised not to procreate, but complex cultural, economic and social factors drive many couples to reproduce.
HIV transmission risk can be dramatically reduced through artificial insemination and sperm washing, however most HIV-affected individuals do not have access to technical fertility resources. Programs to reduce HIV transmission should explore a more nuanced, patient-centered approach to reproductive counseling. We propose that peri-conception pre-exposure prophylaxis (PREP) offers an important, potential complementary therapy to counseling programs that aim to decrease HIV transmission while respecting couples’ reproductive freedom.

Hypothesis:
PREP may provide an opportunity to reduce the risk of horizontal transmission for sero-discordant couples (man is HIV-positive) who choose to have children.

Methodology:
Based on a systematic literature review, we propose a conceptual framework that defines critical points of clarification prior to implementation of PREP in a comprehensive HIV reproductive health program. We considered potential PREP efficacy, PREP adherence, HIV resistance, peri-conception HIV transmission risk for male-positive HIV sero-discordant couples, current options for risk reduction, fetal toxicity, and impact of PREP counseling on entry into ancillary health services including PMTCT and HIV care.

Findings:
For sero-discordant couples wherein the woman is HIV-positive and the man is negative, home-based artificial insemination offers the most effective peri-conception HIV-transmission risk reduction and should be encouraged. For couples in which the man is HIV-positive and woman is HIV-negative, limited, unprotected sexual encounters are the only available option for conception. In this context, viral load suppression with antiretroviral therapy (ART) remains the most efficient strategy for minimizing HIV transmission ([1, 2]). If the partner meets criteria to start ART, therapy should be implemented and couples should delay intercourse until the viral load is suppressed. If the affected partner does not meet treatment criteria, couples should be encouraged to delay conception until ART can be initiated. For some, this may not be consistent with fertility goals. Limited, unprotected intercourse without a suppressed viral load reduces risk by decreasing exposure, but does not reliably minimize horizontal HIV transmission ([3, 4]).

There is a high level of biologic plausibility that peri-conception PREP could decrease HIV transmission when deployed as part of a broader harm-reduction reproductive health program. Unlike PREP scenarios currently being tested in clinical trials, PREP as part of fertility counseling could be time-limited to periods of planned conception, thus minimizing side effects, toxicity, and promoting adherence. A comprehensive, patient-centered reproductive health program would also create opportunities to draw HIV-infected individuals into care.

By offering a novel prevention strategy and addressing couples’ desire for children, such a program may enhance uptake of voluntary testing and counseling, thus facilitating new diagnoses and identifying high-risk individuals. An aggressive, pre-natal counseling program would also promote early linkage to PMTCT (in the case of HIV-positive women). Peri-conception PREP would prove unique in offering a protective option that a woman could implement to reduce her risk independent of her partner’s participation.

Risks of peri-conception PREP are teratogenicity and HIV resistance. Animal data suggest a low risk of adverse events with short-term exposure to tenofovir (the agent principally used in PREP trials). Ongoing clinical trials may offer more data with respect to fetal outcomes. Without clear data to support human fetal safety, it will be crucial to offer PREP only in the context of close monitoring for pregnancy. Efficacy and safety are paramount concerns, whereas challenges related to adherence, resistance, and behavioral disinhibition could be studied operationally in the context of reproductive health programs.

Initiation of the HIV-positive male partner on ART offers another means of transmission risk reduction in this particular population. Short course HAART may be complicated by the need to wait for viral load suppression prior to conception, and the risk of resistance and toxicity. Peri-conception PREP confers less toxicity risk but has potential for teratogenicity.

Knowledge Contribution:
Simply encouraging HIV-affected couples to abstain from procreation is not a realistic strategy in HIV endemic regions. Peri-conception pre-exposure prophylaxis provides a novel strategy to minimize risk of HIV transmission for individuals of reproductive age in HIV-endemic countries and may add an important piece to counseling programs that both respect couples’ right to reproductive freedom and apply what we understand about transmission to minimize the risks of HIV transmission. Should PREP prove efficacious, the net balance of early antiretroviral therapy versus PREP will hinge on the risk of resistance for antiretroviral therapy versus the risk of teratogenicity for PREP.

References:

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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
Mantsi Elizabeth Teffo-Mensiwa, Wilson Liambila, Saiqa Mullick, Doctor Khoza, Ian Askew, Edwin Maroga
Population Council, South Africa; mmenziwa@popcouncil.org

1. Background/Significance
The Population Council’s Frontiers in Reproductive Health (FRONTIERS) Program, in collaboration with the Ministries of Health in Kenya and South Africa, respectively, developed and tested a novel, practical, interactive, and client-friendly strategy for improving counseling during family planning (FP) consultations. The aforementioned process referred to as the Balanced Counseling Strategy (BCS), was tested and refined in several countries, and involves a series of steps to determine the contraceptive methods that are client specific.

2. Research: State main question/hypothesis
Little attention has been paid to the development and empirical testing of practical tools that providers can use to strengthen their capacity to offer integrated services.
Program: State intervention/activity tested
The BCS tested and refined in several countries, comprises a series of steps to determine the contraceptive method that best suit the client according to his/her preference and needs. The BCS was revised to integrate STI/HIV prevention counseling, risk assessment, and HIV counseling and testing (C&T). The resulting Balanced Counseling Strategy Plus (BCS+) tools improves the quality of FP services and allows provider to address STIs and HIV during the same consultation.
3. Methodology (including location, setting, period, analysis approach)
The FRONTIERS program developed and piloted the BCS+ in Kenya and South Africa owing to both countries high rates of STIs, including HIV, and their contraceptive prevalence rates that are relatively high for the region. This approach provides opportunities to reach a substantial proportion of the sexually active population. Like in most countries, their FP and HIV programs are implemented separately, although both countries are actively seeking, through both their ministries of health, to develop practical tools for an integrated approach.
4. Data (if relevant)
5. Findings
Integrating STI/HIV prevention counseling and risk assessment with offering HIV C&T during family planning consultations is feasible and acceptable to clients and providers.
The quality of care for both family planning and STI/HIV counseling improved significantly with the use of BCS+ tools
Use of BCS+ tools facilitated greater risk assessment for STIs and HIV. Also, decisions about contraceptive method choice were made with a better understanding of their relationship to infection prevention
6. Research: State knowledge contribution
Empirical research indicate, inter alia, that using the BCS strategy improved the quality of the provider’s counseling and allowed the client to take ownership of the decision Use of the BCS+ algorithm increased the likelihood that providers would offer C&T, and that the offer would be accepted. Nearly all providers who used the algorithm, the cards, or both mentioned C&T, compared to 65 percent when no materials were used.
Program: State lessons learned
Scaling up of the BCS+ strategy as a practical, interactive, low cost and client driven tool to integrate HIV into FP services is recommended, because it is easy to adapt to local context.

**E08: Contraceptive Failure, Unwanted Pregnancy and EC**

**Time:** Tuesday, 17 November 2009: 4:00pm - 5:30pm

**E08: 1**

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

*Clementine Rossier*, André Soubeiga, Nathalie Sawadogo

1Institut National d’Etude Démographiques, France; 2Université de Ouagadougou, Ouagadougou, Burkina Faso; 3Université Catholique de Louvain, Belgium; clementine.rossier@ined.fr

1. Background

In pre-transitional rural African populations, individuals desire to have as many children as possible; pro natalist ideals make sense in a context where children cost little and where resources and power are gained through extended family relations. Although the need for family planning is low (women resort to abstinence as the main mode of birth control), women can be interested in using modern contraception for health reasons. Men can oppose contraception in these settings, to keep control over their wives’ sexual lives (contraception replacing abstinence) and to take advantage of their reproductive capacities. The role of men is less clear in situations where fertility has started to decline, as is the case in African cities. Men often are the main economic provider of their family in the city, while women usually are homemakers. Urban men may be more keen than women on delaying family formation until they secure a source of income, and on limiting the number of children given the increased costs of education; female statuses on the other hand may remain strongly linked to their reproductive capacities even in the city. In the context of urban Africa, men may thus be the champion of contraception.

2. Research question

The objective of this analysis is to understand under which conditions men help promote contraceptive use in urban Africa, under which situations they demonstrate a persistent opposition or lack of interest for contraception and in that case how women overcome this opposition.

3. Methodology

To explore this complex issue, we adopted a qualitative approach. We performed 77 in-depth interviews (50 with women 27 with men aged 18 to 35) in Ouagadougou, the capital of Burkina Faso in 2005 and 2006. The interviews explore the respondents’ sexual, affective, contraceptive, and reproductive lives, and power relations in the current relation and attitudes towards gender equity. Interviews were taped and transcribed, coded with the software Nvivo. The sample was recruited from diverse entry points, and an equal number of individuals in the different age, marital and educational level categories were interviewed. We adopted a double analytical approach. Working first at the macro level, we describe the two gender systems (tradition and western) which co-exist in Ouagadougou today. We then work at the micro level, and classify our respondent’s current sexual relation according to the level of gender equity / inequity within the couple, using every day decision making and representations of gender roles as classificatory dimensions. To relate the two analytical levels, we place each category of couple power relations within the frame of one of the two gender systems co-existing in Ouagadougou. We then analyze the occurrence of contraceptive difficulties and unintended pregnancies according to the level of gender equity within the couple.

4. Findings

We find that couples inscribed in a Western gender model according to their ideology and most important life decisions can function at the level of everyday decision making with an equal or an unequal share of power; the same is true of couples attached to a traditional gender model. Couples with equitable power
negotiations are common in Ouagadougou, although an unequalitarian (traditional) gender ideology prevails. In couples functioning equitably, both partners collaborate to use contraception or women impose contraception even when men would prefer not using it; these couple encounter some contraceptive difficulties (for example condom slipping), but usually manage to avoid unintended pregnancies, unless both partners are unclear about their child desire. Couples with an unequal share of power can use contraception effectively, when men are in charge of contraception (or decide to use contraception and let women implement their decision). This type of couple is also common in Ouagadougou. Contraceptive failures in that case are rare, unless men choose a method that women do not want, or when women want to conceive. But men in unequalitarian couples can also opposed contraception, whether they want more children, want to control their partner’s sexuality, or want to have sex without a condom or on a fertile day according a priority to their sexual pleasure. Most unintended pregnancies in the sample are concentrated among these couples. The more rresourceless women are in these couples, the more the occurrence of unintended pregnancies is likely.

5. Knowledge contribution

Unequal power relations within couples do not imply systematically a lack of contraceptive prevention, since men often promote and manage contraception in these couples; however, problems arise when men oppose contraception in such couples. In more equalitarian couples, women use contraception even when men are opposed to its use, except in case where child desire or some imperative of sexual life weights more than prevention for both partners at once.

E08: 2

Contraceptive difficulties in Africa: what role for emergency contraception?
Nathalie Bajos1, Agnès Adjagmagbo2, Michèle Ferrand1, Agnès Guillame2, Clémentine Rossier3, Maria Texeira3

1Institut National de la Santé et de la Recherche Médicale, Paris, France; 2Institut de Recherche pour le Développement, Marseille, France; 3Centre National de la Recherche Scientifique, Paris, France; 4Institut National d’Etudes Démographiques, Paris, France; 5Institut National de la Santé et de la Recherche Médicale, Paris, France; clementine.rossier@ined.fr

1. Background

In contexts where unprotected and under-protected sex is frequent, emergency contraception (EC) could represent an efficient means towards the reduction of unwanted pregnancies and unsafe abortions. Indeed, a new type of EC composed exclusively of progesterone and not subjected to medical counter-indications is available since the 2000’s in African countries. Studies on EC undertaken in African countries target specific populations (health care clients, student…) and focus mostly on knowledge and opinions about EC, recognizing that these variables are poor predictors of future use. They do not explore the meaning and place of EC nor do they investigate the barriers to its use.

Our objective is to understand the circumstances under which contraception is not used and failures occur and in which situations EC could be used in Burkina-Faso, Ghana, Morocco and Senegal.

2. Hypothesis

We postulate that contraceptive practices in general, and the use of EC in particular, are embedded in the articulation of social factors which are simultaneously related to (i) reproductive and sexual norms, (ii) gender relations, and (iii) user-provider relations. These factors are often conflicting and contraceptive failures are precisely born from such conflicting configurations, as is the possible use of emergency contraception.

In social contexts where a woman gets no social status if she is not a mother, we consider that the main factor to drive women’s contraceptive practices is the necessity to preserve their fecundity. Furthermore, we hypothesise that women engaged in a socially stigmatised sexuality (such as pre-marital) are experiencing difficulties in accessing contraception. So are women who do not agree with their partner (or the family) on contraceptive decisions, especially if they are facing lack of economical autonomy. The issue of the adequacy of the type of prescribed contraceptive method to social and sexual lifestyles is also central to understand contraceptive difficulties. Finally, the non-acceptance of foreign reproductive products and norms could apply to EC, which is a new hormonal product from Northern countries.

3. Methodology

The analysis is based on 200 semi-structured interviews with women aged between 18 and 35, in Dakar, Ouagadougou, Rabat and Accra conducted in 2005-2006. Respondents have been recruited on the basis of snowball sampling, using different “starting point” (family planning centers, friends, colleagues). Quotas on age, union status and educational background have been established. All the interviews have been conducted in the vernacular language, audio-taped and coded for predetermined and emerging themes with NVivo software.

We have designed a typology of contraceptive situations relying on an inductive approach.

4. Findings

The first and most important group of contraceptive difficulties included all the situations where women agreed to use a contraceptive method to avoid a pregnancy. Those who thought that hormonal contraception could alter their fecundity used condom, withdrawal or periodic abstinence. They were subject to their partner’s refusal to use a condom or to retire before ejaculation, in a social context where men’s sexual needs are believe to be uncontrollable. EC could be used to compensate for non protected sex. The others were likely to used hormonal contraception and faced difficulties during transition period (switching form one method to another), when the method used did not fit with their sexual life (will more likely to be forgotten if irregular sex), when the providers didn’t want to deliver the contraceptive method, and finally some of them did not know how to use the method. EC could be used to compensate for under protected sex.

The second group referred to situations where sexual issues override contraceptive’ ones: when no contraception were used because the woman wanted to preserve her virginity but had finally an intercourse, when sexual desire were so strong that the partners did not think of using a condom, and when non consensual sex occurred to please the man’s sexual desire. As long as women were aware of being at risk, EC could be used in most of these situations.

Finally the last group included the situations in which women did not know anything about fertility and contraception. EC could not be used in such situations. Social factors linked to contraceptive difficulties appeared to be the same in the four countries. But the weighting of the different factors changed from one country to another. For instance, the social stigmatization of premarital sex, leading young people not to use contraception, were important in Morocco and Senegal whereas not involved in Ghana.

5. Knowledge contribution

Our results show the EC could be used in many different situations where women face difficulties in coping with their daily contraceptive practice. These situations cover much more than those were no contraception at all was used. Nevertheless, EC remains seen as altering women’s fecundity. For a real diffusion of EC to occur, women’s right to decide upon their own fertility should become an individual right rather than a simple sanitary right.
Providers’ perspective on emergency contraception and opportunities for enhancing access in Ghana, Burkina Faso and Morocco

Susannah Mayhew

London School of Hygiene and Tropical Medicine, United Kingdom ECAF team; clementine.rossier@ined.fr

EC has the potential to reduce unwanted pregnancies and subsequent unsafe abortions if it is widely used after contraceptive failures or unprotected sex. Health care providers act as ‘gatekeepers’ to people trying to access emergency contraception so it is critical to understand what the providers’ attitudes and views of EC are and how they respond to clients seeking care or help.

Research Questions

This study sought to ascertain the knowledge, attitudes and practice of reproductive health providers regarding emergency contraception in order to inform policy and programme recommendations to enhance access to EC in Africa.

Methods

46 semi-structured interviews were conducted with providers of reproductive health services in Ghana, Burkina Faso and Morocco. The purposive sample of providers included those from public and private sector facilities (including pharmacies). A range of ages and professional levels were included; two-thirds were female and most were over 40 years of age. These interviews complemented those conducted with men and women that are discussed in the other presentations in this panel. Interviews were analysed using AtlasTi.

Findings

Wide knowledge and acceptability of EC:

Providers in all three countries displayed widespread knowledge: virtually all providers in Ghana and Burkina had heard of EC and most had given it. In Morocco two-thirds had heard of it and half had given oral contraceptives for EC. There was widespread acceptance of the EC pill for a range of professional reasons across the three countries: to reduce unwanted pregnancies; reduce unsafe/illegal abortion; as an entry point for regular family planning (especially in Ghana); to avoid side-effects of oral contraceptives given as EC. There were virtually no concerns that it might be abortive and only in Burkina, where FP use is extremely low, were there concerns that regular use of EC might displace regular contraception (specifically condoms, thus increasing HIV risk). More concerns were expressed about the health consequences of frequent EC use and for this reason most providers in all countries preferred to see EC provided through health facilities and pharmacies with trained staff, though were happy for EC to be a non-prescription drug.

Missed opportunities for EC use:

Our findings suggest that, despite high awareness and acceptability, there is a major missed opportunity in the provision of EC. Although two-thirds of providers in Ghana and Burkina and about half in Morocco had ever given EC to clients, most reported giving EC when the client specifically asked for it rather than initiating it themselves at family planning consultations or when the client came with a contraceptive failure or having experienced unsafe sex. Many providers preferred to ‘wait and see’, then counselled the client to keep the pregnancy or, if the client insisted, refer them for abortion. In Morocco providers seemed more reluctant to intervene, though this may reflect the lack of availability of the dedicated EC pill and the somewhat lower awareness of EC in general.

A typology of providers

A typology of providers was developed to inform programme and policy interventions. The typology consists of eight types in four categories: unfavourable (two providers, both Moroccan); reluctant (five providers most from Morocco and Burkina); cautious (18 providers, mostly from Burkina) and enthusiastic (mostly from Ghana and Morocco). Providers in the ‘unfavourable’ and ‘reluctant’ categories tended to be the lower levels of staff and those who had never or infrequently provided EC. Those in the ‘cautious’ category were mostly mid-ranking professionals (nurses, midwives, pharmacists) with a range of EC provision experience (from a little to a lot); those in the ‘enthusiastic’ category tended to be more senior staff who had given a lot of EC. This suggests that training, educational level and provision experience may contribute to favourable attitudes towards EC.

Knowledge contribution and lessons learned

This study has identified encouraging signs of in-principle acceptance of EC including, importantly, little objection to EC on grounds of abortion or FP-displacement. The study has also identified missed opportunities for providing EC which need to be addressed. Opportunities for enhancing provision of EC in Africa include:

- Staff in-service training, as well as pre-qualification curricula, to cover:
  - routinely discussion, during FP counselling, of contraceptive side effects, dangers of contraceptive failure and the need to urgently take EC or seek help in cases of missed pill, condom breakage etc.;
  - provider-initiated promotion of EC during FP consultations or when clients present early after unsafe sex.

- Scaling up the supply and provision of EC in health facilities and pharmacies in all three countries to maximise the widespread acceptance of EC among providers;

- Tackle low public awareness of EC, resulting in low demand, through provider-initiated promotion and possibly wider media campaigns developed on a country-specific basis.

Entry into sexuality and access to contraception: Comparing Morocco and Senegal

Agnès Adjambagbo¹, Fatima Bakass², Pierrette Koné³

¹Institut de Recherche pour le Développement, Marseille, France; ²Institut National de Statistiques et d’Economie Appliquée, Rabat, Morocco; ³Santé Reproductive et Genre, Dakar, Senegal; clementine.rossier@ined.fr

1. Background

In most developing countries, delayed ages at marriage encourage the development of premarital sex, and re-define the issue of prevention at sexual initiation. Senegal and Morocco are among the countries where the gap between first sexual intercourse and first marriage is widening and where premarital sex remains submitted to social regulations limiting its practice and rendering young people’s access to contraception problematic. In this context, sexual initiation is a time of important health (unintended pregnancies, STIs, clandestine abortions) as well as social (social and familial reprobation) risks which are well described in the
literature. Studies agree on the necessity of reinforcing family planning programmes targeted to young people, but rarely focus on the social context which nevertheless determines whether such programmes will be successful.

Our objective is to understand the conditions of entry into sexuality in two African cities (Rabat and Dakar) and to study the impact of different reproductive health policies on this phenomenon. Morocco has implemented early successful family planning programmes, while in Senegal, such programmes have started much later and have long been left to the initiative of the private sector.

2. Hypothesis

The existence of strong family planning programmes is a necessary but insufficient condition to enable women’s access to contraception. Their success depends also on their capacity to answer specific social demands.

The recourse to contraception at the time of first sexual intercourse is often problematic because the latter behaviour remains socially forbidden, especially for women. The norm of virginity, especially influential in Morocco, less important in Senegal, impacts the ways individuals, especially women, enter their sexual lives, and their use of contraception.

3. Methodology

The analyses draw on 150 life histories realized in the two cities in 2006-2008 (50 women and 25 men in Rabat and Dakar). The samples were first recruited randomly (encounters in health centres, the street, different neighbourhoods of the capital cities). In a second stage, the samples were enlarged using the “snow ball” technique. A predefined number of individuals were interviewed in each educational, age and marital status category. In each country, a typology of sexual debut was elaborated, situating first sexual intercourse in each personal history (age, educational or professional situation, type of relationship with the partner, contraception).

4. Findings

In Dakar, like in Rabat, women’s sexual initiation occurs under very diversified circumstances. Sexual debut often takes the form of a process rather than that if an act clearly defined in time. The analysis of amorous relationships where the two partners practice a superficial or non penetrative sexuality is especially revealing of the different steps of such a process. Sexual debut can be early or late, and can happen in the frame of a formal union, in a durable relation with marriage projects, or within an occasional relation. It can be forced or desired.

In every case, the use of means to prevent unintended pregnancies and STIs is not systematic, and depends on the circumstances in which sexual intercourse occurred. Men’s entry into sexuality is as diversified as women’s. However, in Dakar like in Rabat, the fact that they are not concerned by the injunction to virginity changes radically the issue of prevention.

Although one could have thought that the existence of stronger family planning programmes in their country would render the young people of Rabat more serene regarding their entry into sexuality, the interviews show exactly the opposite. In both cities, the entry into sexuality provokes a number of normative tensions from which many difficulties in the management of contraception follow, including when sexual debut occurs within marriage.

The social risks linked to the loss of virginity and to the occurrence of a premarital pregnancy are lived less dramatically in the capital of Senegal. In Morocco, on the other hand, the loss of virginity or even worse, the birth of a child, amounts to a real banishment from society.

The absence of a social acknowledgment of young people’s sexuality constitutes a very important obstacle to the implementation of adequate contraceptive services.

5. Knowledge contribution

Beyond reproductive health policies, social realities are determinant to explain the conditions surrounding first sexual intercourse. In Morocco, reproductive health policies are in contradiction with individual practices. While they are particularly active in promoting the two-children family norm implying the recourse to hormonal (pill or mechanic (IUD) contraceptives, they refuse to take size of a reality which is self-evident for young people today, that of the disconnection of sexuality and marriage. Surprisingly, although Senegal is comparatively late in the diffusion of modern contraception, Senegalese programmes offer a framework which is relatively more open to the sexuality of non married young people and young Senegalese have better contraceptive and STIs prevention practices.

F08: Harnessing Social Institutions to Support FP

Time: Tuesday, 17 November 2009: 4:00pm - 5:30pm

F08: 1

Engaging Muslim Leaders in Support of Family Planning in Tanzania

Gregory Kamugisha
Futures Group International, Tanzania/Health Policy Initiative, Tanzania; GKamugisha@futuresgroup.com

Background/Significance: In Tanzania, unmet need for family planning (FP) exceeds modern contraceptive prevalence, at 22 and 20 percent, respectively. Associated with that, the total fertility rate has remained very high; on average, each woman bears nearly six children during her reproductive years, compared with the worldwide average of 3 children. The maternal mortality ratio has also risen to one of the highest in the world, from 529 deaths per 100,000 live births in 1996 to 578 deaths per 100,000 live births in 2004-5. Young women are at even higher risk because two-thirds of women (65%) are married by their 20th birthday; almost two in three women age 20-24 are sexually active by the age of 18; and half of Tanzanian women give birth before age 20. Additionally, the population continues to grow rapidly, at 2.9 percent per annum, which means the population size will double in about 25 years.

The National Population Policy (2006) cites religious beliefs as one of reasons associated with low modern contraceptive use. Tanzanian people are generally religious, with over 90 percent identifying themselves with a particular religion. About half of the country’s citizens are followers of the Islamic faith. Thus, guidance and directives provided by top Muslim religious leaders on reproductive health (RH) and development issues would potentially have significant positive impact on uptake of FP services.

Program Intervention Tested: The USAID Health Policy Initiative, Task Order 1, initiated an evidence-based advocacy campaign to reach the Supreme Clerical Council for Muslims in Tanzania (the Ulamaa) and seek their support and guidance for expanded use of modern contraceptives among Muslims in Tanzania.

Methodology: In January 2008, the Health Policy Initiative consulted with the National Muslim Council of Tanzania (Baraza Kuu la Waislam Tanzania – BAKWATA), through the Faith-Based Advocacy Group, on the means through which RH needs could be clarified and promoted among Muslim communities in the country. BAKWATA and the Faith-Based Advocacy Group suggested organizing a consultative workshop involving members of the Supreme Clerical Council
of Muslims (Ulamaa), the organization that provides guidance on sacred matters in the Islamic faith. The three-day consultative workshop was organized in March 2008 with 17 members of the Ulamaa. The Health Policy Initiative introduced members of the Ulamaa to the challenges of reproductive health, population, and development the country is facing by using the RAPID computer model as well as other evidence-based disaggregated information, such as indicators on the maternal and child health situation. In addition, the project shared video materials showing clarifications on FP/RH matters and commitment of other prominent Muslim leaders and scholars from African countries, including Mali, Mauritania, Senegal, Ghana, and Uganda.

Participants discussed the presented materials at length, with many opinions regarding whether and how Islam should address FP/RH issues. The Sheikh asked many questions on various issues ranging from health, economic development and demography to other faiths and good governance. At the end of this introductory meeting, a majority of members of the Ulamaa acknowledged the need for issuing an official supportive statement, but also concluded that they would need time to review the presented materials and consult the Holy Books to be in a position to issue the support statement.

To facilitate this process, a small Technical Committee was organized, involving invited Islamic scholars, Muslim women, and members of the Health Policy Initiative. The committee reviewed the reproductive health, population, and development situation in Tanzania; studied relevant passages in Holy Books such as the Holy Quran and Khadiths to identify the link between Holy Books and the reproductive health, population, and development situation; and advised on the approach and premises on which the official Clerical Statement (Fatwa) could be built by considering the intended purpose as well as acceptability to the Ulamaa and Muslim communities.

Findings: In May 2008, the Ulamaa convened for three days for the second time in Bagamoyo, exchanged their findings, and received the report of the Technical Committee with recommendations. The official Clerical Statement (Fatwa), the first ever in the country, in support of Family Planning (defined as Birth Spacing) was framed and issued together with general guidelines through which the Statement would be disseminated to larger community of Tanzanian Muslims, including women.

Program Lessons Learned: The process was largely facilitated by: (i) Making references to Holy Books and linking the teachings to the local evidence and environment; (ii) Showing support of religious leaders from other countries; (iii) Enabling trusted and respected Muslim leaders and scholars to lead the process, which increased participation; (iv) Flexibility in discussion, tolerance, and being accommodative of different opinions as well as focusing on the bigger picture; and (v) Focusing on the contribution of FP to maternal and child health was more persuasive for religious leaders than the challenges of providing education or feeding a larger population because they believe Allah will provide.

F08: 2

Improved Sexual Behavior among Young Women: The Women-LEEP Experience

Oghenefego Onome Isikwenu1, Mary James2, Bridget Anyafulu1, Ebita Ikoghode-Aikpitany3, Tunde Akintoroye4

1Insoro Communications & Media, Nigeria; 2Oxfam Australia; 3Int’l Centre for Women Empowerment & Child Dev; 4Girl Power Initiative, Asaba; 5PET NYSC, Delta state; tigobud@yahoo.com

Background

Women worldwide have been recorded to be the worse-hit in all cases of war, famine, poverty, disease, discrimination and other disasters. The MDGs (1-6) are very much related to women/the girl-child and their development. Family planning is not a culture practiced by the typical African, whether male or female; so interventions addressing this issue have to be innovative and tactical, taking into consideration our traditional and cultural values. This is where Women-LEEP comes into play. An intervention designed to educate, inform and empower young women to take charge of their lives and overcome poverty and hunger through the acquisition of vocational skills for income generation.

Objectives

To provide a platform for social, healthy and motivational interaction among rural women
To build the leadership capacity of women and increase their involvement in decision-making
To equip women with vocational skills for economic empowerment
To educate women on their leadership responsibilities in their homes and communities.

Intervention

The Women Leadership and Economic Empowerment Project (Women-LEEP) has proven to be very effective in communicating positive behavioural changes among young women who have benefited in the last 3years. A well designed curriculum on leadership and interpersonal skills, human rights education and vocational skills acquisition program; beneficiaries have successfully made positive and conscious decision/commitment to live health reproductive lives, delaying sex till after marriage and concentrating on their education.

The pilot project had 35 girls as beneficiaries who went through a 3months leadership, life building/interpersonal and vocational skills acquisition program in 2007. It was then scaled-up to 50 participants in the second phase and this time included young widows and unemployed married women in 2008. In 2009, Women-LEEP was implemented in 3 different communities with 60 beneficiaries and nutrition education for maternal and child health was included in the curriculum. Community peer facilitators were trained to facilitate the trainings in various the communities.

Methodology

The triple-A cycle (Assessment, Analysis & Action) was used in implementing this project. Community meetings with elders to select participants, open community forums to evaluate project and get community perceptions, one-on-one in-depth interviews, questionnaires and focused group discussion. Participants had homework with their families and friends at home; which fostered knowledge sharing and role plays on a weekly basis for 3months period.

Results

The Women-LEEP intervention in its 3years of existence has proven to be very effective in behaviour change communication among beneficiaries, their families, friends and communities. The first phase beneficiaries have all successfully completed their secondary schooling and are waiting to get into higher institutions of learning, living healthy sexual and reproductive lives. All other beneficiaries from phase 2 and 3 are doing well in their businesses since most of them took to the vocational skill acquired for income generation. Communities and families have come to appreciate the female gender and started providing support to engage women in decision-making.

Lesson learnt

The decision to delay sex till marriage, eat healthy and nutritious food, have fewer children and maintain hygienic environment will contribute to eradication poverty, increased literacy, gender equality, reduction on HIV/AIDS, STIs and malaria and improve maternal and child health; which form the crust of the MDGs.
A lot still has to be done because only a few women in Nigeria and Africa have access to such interventions. Interventions should be more holistic to have an all-round impact on beneficiaries; this is also cost effective.

F08: 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

Amos Kankpongani Laar
School of Public Health, University of Ghana, Legon, Ghana; aklaar@yahoo.com

Background/Significance

Local anecdotes and personal communications show that the Ghanaian press is often preoccupied with politics and sports, giving very little attention to health matters. The need for the Ghanaian press to give consideration to reproductive health (RH) issues, particularly family planning, abortion, and HIV stimulates the interest of this paper. Even though it is sometimes argued rather controversially that these issues have been over-flogged, repeating them in the press with the aim of reinforcing the message, educating new audiences and sustaining individual behavior is essential. This is particularly so in a time that RH activists are faced with almost daily task of correcting common misconceptions on some RH issues.

Main question/Hypothesis

Does Ghana’s best selling newspaper give attention and prominence to the following reproductive health issues: family planning, abortion, and HIV?

Methodology

I conducted a content analysis of the Ghanaian Daily Graphic newspaper for coverage of family planning, abortion, and HIV in Ghana. Currently about 40 newspapers are published in Ghana. The state funds two daily newspapers (Daily Graphic and Ghanaian Times) and two weekly entertainment papers (The Mirror, and The Weekly Spectator). The Daily Graphic since 1950 has been the most widely circulated Ghanaian newspaper. Approximately 200,000 issues are circulated daily throughout the 10 regions of Ghana via train, bus, and courier. The universe of this study was the entire editions of the newspaper between January 1st 2008 and March 31st 2009 - exactly 443 editions (there are no issues on Sundays, and statutory public holidays). Relying on previous methods of content analysis, the composite week sampling technique was used. The sampling started with the first edition of January 2008; this was a Tuesday, Wednesday was chosen for the second week, Thursday for the third week and Friday for the fourth week. Saturday was the first edition for February, 2008, Monday, Tuesday, Wednesday, and Thursday were respectively chosen for the second, third, and fourth weeks. The same pattern was used for the rest of the 13 months.

In all, a total of 62 editions were selected. The unit of analysis was the theme of stories – straight news or in-depth analysis (feature, editorial, opinions, and letters to the editor). Prominence or quality of reportage was measured using the headline size, column space/area, and page placement. Enhancement of stories with pictures and picture size were also assessed. To assess trends in coverage over time, the 15 months sampled were grouped into five mutually exclusive periods (comprising three months). The differences in mean coverage across these periods were then assessed using Analysis of Variance statistical technique. Statistical analysis was done using SPSS Version 15.0.

Findings

This review shows that coverage of the four RH issues was incredibly poor. The percent coverage of the RH issues in question was less than 1%. Out of the 4,690 items analyzed (including straight news, features, editorials, and letters to the editor), 197 (4.2%) were on health, 25 (0.5%) on RH; specifically 4 (0.09%) on FP, 2 (0.04%) on abortion, and 19 (0.4%) on HIV. The 62 editions of the paper contained a total space = 2,937,962.00cm². Of this, only, 5,433.95cm² representing 0.2% was dedicated to the RH issues of interest. The mean space allocated to any news item was 75.64cm². For a news item on health, it was 3.18cm², and 0.47cm² for any of the RH issues of interest. Generally, coverage of all the issues considered was comparable across the five periods, F(4, 61) = 1.07; p = 0.38. So was coverage on health, F(4, 61) = 0.96; p = 0.44 and on RH, F(4, 61) = 1.49; p = 0.22. The findings also show that little prominence was given to these RH news items. Mean headline space (range) in cm² was 26.69 (7.56 - 250), and mean column space (range) in cm² was 170.21 (17.6 – 456.00). A considerable proportion of the RH news items (56%) were not enhanced with pictures. Almost all the stories (96%) were straight news and were also relegated to the middle pages (96%) of the papers. The original authors of the 25 news items on RH issues were the Daily Graphic 17 (68.0%), BBC 4 (16.0%), and other Ghanaian newspapers 4 (16.0%). Most of the main speakers in the news were NGOs.

Contribution to knowledge

This analysis has reinforced the current local anecdotal concerns that the Ghanaian press is preoccupied with non-reproductive health issues. The finding is a wakeup call for RH activists to look for innovative ways of integrating RH issues into existing media outlets. Sensitization of staff of existing newspapers on the essence of adequately covering health issues, contributions in the form of feature articles to the papers by RH activists could help in mitigating this problem.

F08: 4

Assessing Quality of Family Planning Service Provision among Private Patent Medicine Vendors in Nigeria

Samson Babatunde Adebayo, Afiya Gofwan, Chinzao Uluju, Richard Fakolade
Society for Family Health, Nigeria; sadebayo@sfhnigeria.org

Background

Contraceptive security exists when every person regardless of socio economic status, geographical locations and ethnic group is able to choose, obtain and use quality contraceptives and other reproductive health products when needed. In Nigeria, findings from the 2003 Nigeria Demographic and Health Survey revealed that more than half (58%) of users of contraceptives obtain their contraceptives from the private medical sectors. The report further indicated that 71% of oral contraceptive pill users get their supply from Chemists which includes Patent Medicine Stores (PMS) or Private Patent Medicine Vendors (NPC [Nigeria] & ORC Macro, 2004). Majority of the owners of Private Patent Medicine Vendors (PPMVs) are without a medical background.

Intervention

To enhance skills on best dispensing practices, Society for Family Health trained over 10,000 PPMVs across the country to improve the availability of and access to Family Planning (FP) products and services to the sub-urban and rural populace. The training allowed the PPMVs to dispense oral pills and refer new clients who require family planning services to a health facility. This paper intends to evaluate the quality of services provided by the trained PPMVs using Mystery client survey and In-depth interviews.

Methodology
Mystery Client Survey is a study in which a pre-recruited person visits an outlet anonymously, posing as a regular client, to assess the quality of customer services based on pre-determined criteria. After leaving the facility, the mystery client fills a survey form detailing the services obtained during the visit to the outlet. This approach presents a woman of reproductive age who visits a PPMV with the intention of obtaining a contraceptive method. Simulated visits which are a core component of the mystery client approach were used to identify key case management practices among the PPMVs. The study was conducted in 4 states: Lagos, Plateau, Enugu and Kano. Each mystery client visited between 6 – 8 outlets per day in each of the identified Local Government Areas (LGAs) or wards where they presented some scenarios. Data were managed and analyzed with Statistical Package for Social Sciences (SPSS) version 11.5. Frequency tables were generated from the data. Hence descriptive inference was employed.

A qualitative study using in-depth interviews (IDIs) was also used to obtain information on reasons why PPMVs do not refer clients to a health facility as it could not be captured with the Mystery client survey. Two IDIs were conducted in each state. Overall, a total of 8 IDIs were conducted.

Findings

A total of 410 PPMVs were sampled from the list of PPMVs trained in the various states. Ninety-four percent of the outlets visited were in the urban and semi-urban areas while only 6% were in rural areas. Results showed that most of the PPMV service personnel understand the importance of referring new clients to a health facility. Approximately 45% of PPMVs referred new clients who require FP products to a health facility. Demand by clients who refuse to visit health facilities necessitates the provision of oral pills to first time users even though PPMVs would actually prefer to refer. Reasons why clients prefer obtaining FP methods from PPMVs could be attributed to the absence of formalities and less time spent at the PPMVs before being attended to. Neatness of the facility to their homes and the perception of clients that they will pay more at a health facility were some of the reasons given by the PPMVs. The following quotes buttress this finding:

“Sometimes if you send them to hospital they will say no they want the medicine”

“There are many reasons why women don’t like to visit health facilities, and not that we don’t refer them. Some after considering the cost of paying transport to the hospital only to get information, they will just buy any pill they have heard other women mentioned. and some women don’t go when you refer them”

About 51% of PPMVs referred mystery clients who presented complications with pills to a health facility. Majority of the PPMVs had pills in stock (84%) on the day of the survey and re-supplied pills to the clients. Only 17% of the clients were advised on how to take the pills. About 22% of clients were told what to do when they miss a pill, 14% were informed about side effects of pills, 13% were told the importance of taking the iron tablets and 39% were informed about other FP methods.

Lessons Learnt

There is a need to improve the capacity of PPMVs through trainings to ensure best dispensing practices of contraceptives and improve the quality of contraceptive supply to the populace as many obtain products and services from the PPMVs.

G08: Effective Programming and Service Delivery III

**Time:** Tuesday, 17 November 2009: 4:00pm - 5:30pm

**G08: 1**

**Campagne Nationale en Faveur de la Planification Familiale au Mali : Contribution au Repositionnement de la Planification Familiale**

*Abdourhamane Maiga, Diallo Haleimatou Maiga, Timothée Gandaho, Lisa Nichols, Keita Binta, Doucoure Arkia Diallo, Konate Ramata Fomba*

Programme Santé USAID/ATN Plus, Mali; amaiga@atnsante.org

1. Contexte/Importance :

Repositionnement des activités de planification Familiale au Mali

2. Recherche : Indiquer la question/hypothèse principale ;

Programme : Indiquer l’intervention/activité avérée

Organisation d’une campagne nationale en faveur de la planification familiale

3. Méthodologie (y compris le lieu, la situation, la période, l’approche adoptée pour l’analyse):

Cette campagne a été organisée sur toute l’étendue du territoire et à tous les niveaux de la pyramide sanitaire pendant un mois (mi- mars à mi- avril) de 2005 à 2009

4. Données (s’il y a lieu) ;

   - amélioration des connaissances des populations sur la planification familiale (une étude menée en 2007 sur les effets de ladite campagne a monté que dans 6/7 des localités couvertes, les participants ont entendu à la radio ou à la télé) ;
   - institutionnalisation de la campagne PF (14 mars) par les décideurs,
   - ouverture d’une ligne budgétaire à partir de 2009 pour l’acquisition des contraceptifs modernes (10% du coût global) par les décideurs ;
   - proposition du renforcement de la stratégie de distribution à base communautaire de contraceptifs modernes par les décideurs ;
   - mise en place d’un groupe multisectoriel pour les activités de PF.

5. Conclusions ;

La campagne PF au Mali a permis de relever les connaissances des populations sur la PF et de relancer les activités de PF.

6. Recherche : Indiquer la contribution aux connaissances ;

Programme : Indiquer les leçons tirées.

L’implication de tous les acteurs notamment les décideurs et les communicateurs, la décentralisation des activités de PF, la formation des prestataires, le renforcement du système d’approvisionnement en contraceptifs modernes et le choix de meilleures stratégies de communication sont des éléments indispensables pour la réussite des programmes de PF.

**G08: 2**

**Family Planning Implementation Teams: Building Sustainable Community Ownership in Rural Uganda**
Joan Patterson1, Paige Anderson Bowen1, Heather Lukolyo2, Laura C. Ehrlich1, Diana K. DuBois1

1Minnesota International Health Volunteers, United States of America; 2University of Minnesota School of Public Health, United States of America; lehrlich@mihv.org

Background

Minnesota International Health Volunteers (MIHV) is improving family planning knowledge, access, and use in two rural districts of central Uganda: Ssembabule and Mubende. MIHV’s U.S. Agency for International Development (USAID)-funded Uganda Child Spacing Project (UCSP) uses a community-based strategy to increase demand for family planning services and to increase supply of family planning methods to women and men who choose to use them. A critical component to this strategy is the Family Planning Implementation Team (FPIT), established in both districts to facilitate and coordinate MIHV’s community-based family planning work. The purpose of this abstract is to describe how the FPITs have contributed to the successful implementation of UCSP, as well as some lessons learned which may be useful to other organizations that are implementing community-based family planning programs.

Intervention

FPITs are based on principles of multi-sector team building, community empowerment, and leadership and foster community ownership of the project. The FPIT meetings are held quarterly and are intentionally kept small, to facilitate unconstrained discussion. Membership includes the District Health Officers (DHO) or representatives from his/her office, the Community Development Officer, a representative from the network of MIHV-trained family planning community health worker (FPCHW) volunteers, MIHV program and operational staff, and other key family planning/reproductive health stakeholders. Initially facilitated by MIHV staff (with subsequent turnover to the DHO’s staff), FPIT meetings provide a forum to review progress, share ideas, discuss challenges, and identify areas for collaboration, all contextualized with discussion of community norms and beliefs.

Methodology

A case study was conducted in February and March 2008 compiling the following information: 1) review of project documents (including FPIT meeting minutes), 2) key informant interviews with project staff, FPIT members and other stakeholders (n=8), and 3) observations of FPIT quarterly meetings in each district. Interviews were conducted in English using a 12-item open-ended questionnaire. Content analysis of data identified major themes and specific outcomes of FPIT activity and operation.

Findings

Overall, FPITs provide a significant coordination and sustainability role for family planning program activities within each district. The following examples illustrate FPIT contributions:

• Defining the profile and role of the FPCHW, and determining the acceptable limits of the FPCHWs’ work;
• Recommending that traditional birth attendants (TBAs) and traditional healers not be trained as FPCHWs;
• Proposing that family planning and child health outreaches be integrated;
• Suggesting Family Planning Days and other activities to improve UCSP’s reach to men;
• Uncovering violations of the free contraceptives distribution policy in the government health system;
• Reversing negative attitudes and beliefs about family planning;
• Suggesting strategies to keep FPCHWs motivated to continue their volunteer work;
• Developing mechanisms to ensure sustainability of the project after the funding cycle ends;
• Reviewing and improving the UCSP’s monitoring and evaluation system.

Lessons Learned

MIHV has learned several important lessons through its experience working with FPITs, including:

• Multi-sectoral teams boost creativity, idea generation, community ownership, and advocacy power;
• A system for following up on recommendations should be established within the team;
• FPIT membership must be balanced between stable, long-term members and emerging community leaders;
• FPITs contribute to the formative evaluation at each step of the project.

MIHV’s evidence to date strongly suggests that building sustainable community support for family planning is enhanced through use of FPITs and community ownership of the FPIT process. While team memberships and duties should be tailored according to each location and its situation, each FPIT should include a cross-section of stakeholders and should meet regularly. Flexibility and follow-up are vital to maintaining interest and enthusiasm. Other organizations working in community-based family planning can adopt similar approaches.

G08: 3

The Confidence Family Planning Network: using a social marketing network to re-establish FP in a post-conflict DRC

Jamaica Corker

Population Services International, United States of America; jcorker@psicongo.org

1 Background/significance

Prolonged armed conflict in the DRC from 1994-2003 resulted in an estimated 5.4 million excess deaths (IRC 2008) and devastated the country’s health infrastructure and services. The conflict also resulted in limited access for over ten years to FP services, information, training and products. This resulted in a lack of trained FP providers and unavailability of contraceptives, leading to an unprecedented decline in the CPR of modern methods in DRC, from 15% prior to the outbreak of hostilities to 4.4% in 2001 (UNFPA 2007). The 2007 DHS for DRC showed that over 57% of Congolese women wish to space or limit their births but only 5.8% are currently using modern methods; an additional 14% use traditional methods, either out of choice or due to a lack of access to modern methods.

Government and donor funding priorities for the DRC have been focused on security and stability; attention to and financing for rebuilding the country’s health system have lagged behind. Even within health financing, funds are divided between many pressing health priorities and family planning is not at the top of the agenda. This despite the ‘lost decade’ of FP, during which product delivery, FP training for health professionals and basic FP services all but disappeared.
Although the public health system was almost entirely destroyed, many of DRC’s private (or quasi-private, given that even private health clinics are overseen by the public health system) continued to function at a basic level throughout the decade of civil unrest. These clinics offered the best opportunity to quickly reintroduce FP products and services in major cities in DRC following the cessation of the majority of hostilities in 2003.

2. Program: State intervention/activity tested

PSI/DRC’s franchise approach increases access to and use of modern contraceptive methods in DRC by promoting FP information, services and products via existing health care service providers, using a network of functioning quasi-private and public clinics which meet established minimum standards, in addition to private pharmacy partners.

Active in fourteen of DRC’s largest urban centers, PSI/DRC’s Confinence network includes 78 clinics, 277 pharmacies and 113 mobile community educators, and is supported by a wide range of mass media and IPC activities to increase knowledge of and demand for FP throughout DRC. The network offers a comprehensive range of family planning products (two oral contraceptive pills, a three-month injectable, IUD and CycleBeads) and services through its network of trained providers and distribution sites.

3. Methodology

An analysis of growing demand for contraceptives since the cessation of hostilities (PSI/DRC will more than double distribution objectives for nearly all products by the end of project, due to under-estimations of demand and program growth potential at the outset of the project) and results from the 2007 DHS, coupled with earlier CPR data, will be presented to try and demonstrate that much of the current FP program work in DRC is re-introducing FP after an ‘unnatural’ interruption in the form of prolonged civil conflict.

4. Data (if relevant)

The 2007 DHS, the only comprehensive health study in DRC in over twenty years, will be the main source of data, particularly to illustrate use of public and private FP providers (for example, nearly two-thirds of all contraceptive users get their supplies at private pharmacies) and demand for FP. Data from PSI/DRC’s upcoming TRAC survey (scheduled for July 2009, to collect data on the impact of the 5-year FP program) will be used for details on FP attitudes and practices in PSI/DRC’s intervention sites.

5. Findings

Building an FP franchise based on pre-selected clinics which continued to function following the war allowed PSI/DRC to re-introduce FP training, services and products into existing, independent clinics in DRC’s largest cities despite the fact that the public health system was decimated and slow to recover in the years following the devastating civil conflict. While not a substitute for rebuilding a public health system, by identifying what still functioned in the post-conflict health system establishing FP activities there, the social marketing network made crucial headway quickly on FP/RH interventions in urban areas where FP had been more widespread before the war, while the public health system remained crippled from the destruction of the health infrastructure during the civil war.

6. Program: State lessons learned

- Comprehensive provider trainings were a crucial aspect of the network program, as many new clinicians and pharmacists had received no FP training and older health professionals had information that was often extremely out-dated.
- Estimates of FP demand and program growth should have given more consideration to the previously higher CPR levels (15% prior to the civil unrest) and assumed greater demand and growth based on a ‘catch-up’ strategy.
- More financing and attention could have been diverted to provider trainings and product procurement/distribution, and less to communication and demand creation, as the early stages of the program reached out to the very ‘low hanging fruit’ that already knew of and/or used FP prior to the decade of conflict.

G08: 4

Policy imperatives for systems oriented approaches to scaling up: Case example of taking a new family planning method to national scale

Susan Igras, Rebeca Lundgren, Marie Mukubatsinda, Arsene Binanga, Foufa Toure

Institute for Reproductive Health/Georgetown Univ, United States of America; smi6@georgetown.edu

Background/Significance

Scaling up is often conceptualized in too simple terms, with policy makers and program planners assuming that once a new service is found in norms and guidelines and service providers are trained, scaling up is achieved and a new service will be sustainably introduced. The literature indicates that important, less proximal factors are often ignored when planning scale up, including the capacity of existing systems to support and sustain integration as well as how negatively or positively the larger political, economic, and social environment enables a scaling up process. Scaling up has always been a mandate of governments and increasingly it is an aim of donors with RH agendas. To be a cost-effective endeavor, conscious efforts are needed to select which technologies/services to take to scale and to plan and manage scaling up processes to ensure that, at the end of the day, selected technologies/services will be sustainably introduced and populations will benefit from increased access to new services.

Intervention/Activity Tested

IRH has been working over several years with Ministries of Health and other family planning actors in a variety of countries to take to scale the Standard Days Method of family planning. The WHO/Expandnet scaling up model has been adopted by IRH to guide a facilitated process to analyze, plan, gain political commitment, and mobilize support for scaling up efforts in Mali, Madagascar, and Rwanda.

Methodology

Through continuing and stakeholder strategic planning, the systems-oriented ExpandNet model has helped policy makers, program planners, and technical assistance organizations to conceptualize scaling up a new family planning method as a complex managerial and political process, gain political commitment, and mobilize the range of actors involved in FP programs to support the scaling up effort.

Data

Findings from baseline research on scaling up the SDM (policy makers, program manager, and service provider interviews, plus facility audits and community-based surveys) sand process documentation (FGDs with stakeholders at different points in the scaling up process) will illustrate key aspects to consider in early phases of scaling up the SDM.

Findings
The presentation will focus on how use of the ExpandNet model has increased systematic engagement of key actors and has addressed potential political, management, and resource pitfalls before they materialize. It will also highlight challenges to-date in supporting and monitoring scaling up of the SDM and emerging lessons learned and better scaling up practices in Mali, Madagascar, and Rwanda.

Knowledge contributions / Lessons learned

To be cost-effective, scaling up processes need to be systematic yet flexible, systems-oriented, engage a variety of FP actors as well as be cognizant of and manage political and other factors outside the immediate FP program environment that enable and constrain scaling up processes. The complex nature of scaling up needs to be better understood by policy makers, program planners, and technical assistance organizations in order to make good use of resources, help ensure sustainability of the scaling up effort and bring maximum benefit to a country’s population.

G08: 5

Integrated Family Health Program Helps Family Planning Compliance Among Women Using After the First Child.

Tawhida Khalil, Douglas Storey, Don Hess
JHU SPH, Egypt; tkhalil@jhuhcp-eg.org

1. Background/Significance:
The Communication for Healthy Living (CHL) program (2002-2011) aims to increase people’s ability to respond to health challenges they face at each stage of family life. By providing life stage appropriate health information and improving health related practices at early stages of family life, CHL attempts to increase healthy behaviors at later stages of family life and across a broad range of health areas from ante-natal care, safe delivery, post-natal care, family planning, maternal and child nutrition, hygiene, passive smoking, breast cancer, and avian influenza.

CHL is implementing a community-based program in close collaboration with HCP partner Save the Children. The program consists of a package of interventions designed to improve the health of individuals, families, and communities. Local Community Development Associations (CDAs) in the focal villages are at the center of the program, and take on the role of mobilizing and empowering the community through health-related activities.

2. Research: State main question/hypothesis

An integrated family life stage approach allows programs to encourage a broader household health competence mentality that helps people to respond proactively to new health challenges as they arise at later life stages especially in relation to antenatal care and family planning practice.

3. Methodology (including location, setting, period, analysis approach):

In 32 intervention villages in three governorates, local NGO outreach complements national efforts. Family health interventions are implemented through CDA volunteers. These interventions are:

a. Visits to newlyweds to introduce the health activities available in the community and provide counseling on family health issues.

b. Ante-natal and safe delivery classes for pregnant women. (Adapted from Improving Pregnancy Outcomes Through Positive Deviance – IMPRESS.)

c. Post-partum home visits from nurses and volunteers, with information on proper breastfeeding, importance of initiating family planning method within 40 days of delivery, and monitoring health of mother and infant. (Adapted from IMPRESS.)

d. Health and nutrition classes for mothers with identified at-risk children. (Adapted from Nutrition, Education and Rehabilitation Program – NERP.)

Data come from three waves (2004, 2005, 2008) of a panel survey (n=3171 married women aged 15-49) in 8 intervention and 2 control villages in three governorates of Upper Egypt. MCH monitoring data from the outreach efforts in 32 villages are also used to track the behaviors and health status of 13,989 women and their children.

4. Data (if relevant):

Comparing women in the outreach program with women in control villages (national program only), 68% vs 46% initiated FP use after one child, 86% vs 58% had 5+ ANC checkups, and 96% vs 40% reported handwashing before feeding their children.

5. Findings

Providing appreciated health information at an early stage of marriage helps a sustained improvement of health behaviors, especially those related to family planning and child health. Couples who were involved in the program as early as marriage had shown a sustained positive behaviors in relation to antenatal care, safe delivery, early initiation of breast feeding and improved family planning practice in both continuation and spacing between pregnancies.

6. Research: State knowledge contribution

Comparing women in the outreach program with women in control villages (national program only), 68% vs 46% initiated FP use after one child, 86% vs 58% had 5+ ANC checkups, and 96% vs 40% reported handwashing before feeding their children.

An integrated family life stage approach allows programs to encourage a broader household health competence mentality that helps people to respond proactively to new health challenges as they arise at later life stages.

This program provides evidence that combination of horizontal integration among health areas helps families to gain health information which helps them through vulnerable periods. In addition, generational effect is observed among targeted groups in the form of better compliance in family planning practice and better child health, especially during infancy and early childhood.
Wednesday, 18 November 2009

A09: Mobilizing Commitment and Funding for FP

Time: Wednesday, 18 November 2009: 10:30am - 11:45am

A09: 1

The Fall and Rise of the Green Star: An analysis of effects of program restructuring to the weakening of the Tanzania National Family Planning Program and advocacy efforts to revive it.

Christine Lasway1, Maurice Hiza2
1Family Health International, Tanzania; 2Tanzania Ministry of Health, Reproductive and Child Health Section.; clasway@fhi.org

1. Background/Significance

Repositioning family planning has become an important advocacy initiative across sub-Saharan Africa (SAA) with a fundamental goal of mobilizing political commitment and resources to strengthen family planning services. The focus of this initiative across many SAA countries is on enhancing and reshaping the advocacy argument of family planning as a priority public health intervention and its role in national development. Whilst this is a strong evidence-based advocacy argument, the sustainability of its impact could be strengthened with better understanding of how interventions that target the policies and reforms that led to the reduced and/or ineffective allocation of limited resources in the first place are taken into account.

2. Program: State intervention/activity tested

The intervention to reposition family planning as a priority in the national development agenda involves a series of well-coordinated systematic efforts in various dimensions and levels, leading to various measures of success including the revival of the national family planning working group, multi-level advocacy campaigns, rebuilding of the champions initiative, the development of a national funded implementation plan for family planning, and focus on more cost-effective strategies to programming, integration into other health areas and revitalization of long-acting and permanent methods.

3. Methodology (including location, setting, period, analysis approach)

The methodology involves the review, analysis, and documentation of programmatic interventions implemented by multiple partners prior to 2006 and thereafter. Information on the issues surrounding the stagnation of family planning program resources are obtained from an extensive body of data and documentation on family planning in Tanzania, including project and program progress reports; technical analyses; operations research; and statistical surveys, as well as key informant interviews with multi-sectoral stakeholders.

4. Data (if relevant)

N/A

5. Findings

Information presented will show that in Tanzania, similar to other SAA countries, resources for family planning stagnated or fell, even as FP demand rose. It will explain the main reasons pertaining to the challenges and constraints encountered in implementing the Tanzania National family planning program as well as how the financing structure and policy changes affected the trends in levels of support to the family planning program. Specifically, the presentation will seek to explain that in addition to the diversion of resources to the HIV/AIDS pandemic and to high maternal and child mortality rates, a shift from a vertical to horizontal approach to financing and programming considerably contributed to loss in momentum of the national FP program or “falling of the green star”. Programmatic experiences will be presented on multi-pronged efforts to bring back the green star. It will show how repositioning efforts are taking a systematic coordinated effort by looking at the root causes of the problems and developing solutions to address them with a sustainable vision in mind.

6. Program: State lessons learned

The presentation will contribute to increased knowledge towards strategically implementing advocacy efforts to reposition family planning in countries similar to the Tanzanian context, with an emphasis on addressing policies and financing structures that led to the reduction or diversification of resources. Furthermore, it will show how it may be useful to take on a dual approach of advocating for family planning financing in a vertical manner to bring attention to the cause, as well as implementing family planning in a horizontal manner, such as integrating family planning into other well-resourced service delivery efforts.

A09: 2

Engaging the Poor on Family Planning as a Poverty-reduction Strategy

Imelda Zosa Feranil1, Cynthia Green5, Wasunna Owino1, Laurette Cucuzza1
1CEDPA, United States of America; 2Futures Group, United States of America; iferanil@futuresgroup.com

Background/Significance

Efforts to address poverty in many countries have had mixed success. International development experts have cited several underlying reasons why this is the case. One reason refers to the need for policy and decision-makers to bring the poor in the design and implementation of poverty-reduction policies and programs. A second reason involves the lack of explicit consideration of family planning in poverty initiatives. The main theme of this paper is that policies and programs that combine poverty-reduction and family planning initiatives, as well as engage the poor, can increase the effects of both initiatives.

Hypothesis Tested

This technical paper puts forth voicelessness as a key dimension of poverty, and that compared to the wealthiest women, the poorest women are at a disadvantage because they are more likely to become mothers at very young ages, bear many more children, give births without medical attendance, and have limited access to family planning information and services.

Methodology and Data

Existing statistics and studies were analyzed and synthesized for this paper. Demographic and health surveys conducted in various developing countries all over the world were a major source of data, along with fertility and poverty studies conducted or reviewed by international organizations. The results of the analysis were combined with information from past and current activities of the USAID Health Policy Initiative, including pro-poor activities in Kenya, to prepare the guidelines for engaging the poor that appear at the end of the report.

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Findings include:
1. Poverty concepts having evolved to incorporate the poor’s voicelessness and isolation.
2. In most developing countries, the poorest people typically having more births, more early births, the largest number of children, the lowest use of family planning, and the highest unmet need for family planning, compared with people who are better off. These factors combine to make the poor remain poor; they severely limit families’ prospects to improve their quality of life.
3. Meetings with community leaders and members of urban and rural poor areas in Kenya revealed very limited efforts of key decision-makers to engage the poor in funding and programming decisions. But Kenyan informants also pointed to national/regional leaders who have reached out to them. Urban and rural poor residents have also concrete ideas on how best they can be engaged and participate in making their own communities and lives better.

Knowledge contribution and lessons learned
The technical report served as basis for developing practical guidelines addressed to national and local leaders and FP/RH advocates on ways they can engage the poor in all phases of policy formulation and implementation:
• Problem identification - the poor can give insights into their day-to-day worries, factors that affect their ability to access services, and cultural norms and practices that enable or restrict them.
• Policy formulation. The poor can advise on the appropriateness and feasibility of various policy options and advocate for adoption of the policy and allocation of the necessary resources.
• Policy implementation. The poor can explain why programs designed by outsiders are likely to fail. Furthermore, they can take an active role in program implementation by encouraging community participation and serving as trusted sources of information and supplies.
• Policy monitoring. The poor can provide important feedback regarding the reach and effectiveness of policy initiatives.

A09: 3
Use of the RAPID Model for Advocacy with High-level Decision-makers
Thomas Goliber
Futures Group International, United States of America; TGoliber@futuresgroup.com

Background: In The Origins and Evolution of Family Planning Programs in Developing Countries, Judith Seltzer accurately points out that the fundamental arguments in support of family planning programs existed in their basic form from the beginnings of such programs in the 1950s and 1960s. These include (1) the health rationale: family planning promotes the health of mothers and children and other family members; (2) the human rights argument: family planning helps people decide, freely and responsibly, the size and spacing of families; and (3) the population and development position: family planning can help lower high fertility and high population growth rates, thereby contributing to the ability of countries to achieve their social and economic development objectives.

At different times and in different places, one or another of these arguments has received special emphasis, though none of the three have ever been completely absent. For example, the population and development argument held sway in much of Asia during the 1960s and 1970s. The International Conference on Population and Development (ICPD), held in Cairo in 1994, gave a strong voice to the human rights rationale.

Recently, in sub-Saharan Africa, there has been a renewed emphasis on using the population and development rationale as a way to strengthen high-level political commitment for repositioning family planning initiatives. This renewed interest is driven by many factors including (1) the slow pace of fertility decline and modest increases in contraceptive use in many countries; (2) a strong interest in poverty alleviation and achieving middle-income economic status, as reflected in national vision statements; and (3) a keen concern with achieving the Millennium Development Goals (MDGs).

Research Question: Given the renewed emphasis on population and development rationales to build political support for family planning, the research issue is to assess the content of arguments being used with African policymakers. This assessment can then be used to strengthen advocacy messages and strategies in different settings.

Methodology: The RAPID Model is one of the tools used to convey population and development issues to high-level policymakers. RAPID is a component of the SPECTRUM suite of reproductive health policy models. It is designed to use alternative population projections to explore the question: what difference would a lower rate of population growth make to the ability of a country to achieve its social and economic development objectives? The results of the RAPID Model application are packaged with information from other sources into a PowerPoint presentation and a briefing book to be used in high-level policy dialogue. A RAPID application is typically hosted by a leading national institution such as the Ministry of Health, the Ministry of Planning or the National Population Commission. The RAPID model, presentation and briefing book are developed by an expert team which often includes an international consultant.

We propose to analyze the content of several recent or ongoing RAPID presentations—e.g. Benin, Ethiopia, Kenya, Malawi, Rwanda, Senegal, Tanzania, Zambia—to give examples of the advocacy messages and strategies that are being used with African policymakers.

Findings: RAPID is one of the important tools being used to advocate for repositioning family planning initiatives in sub-Saharan Africa. Collectively, the RAPID presentations indicate that expanded family planning programs can in fact make a fundamentally important contribution to African development. Some of the key messages are
• A lower rate of population growth can help countries accelerate economic growth and move more quickly to achieving middle-income status;
• Lower fertility creates a path out of poverty for many families;
• By lowering dependency ratios, declining fertility can create a “demographic dividend” that can help countries achieve economic expansion;
• Continued high fertility can undermine national security by creating an ever-expanding “youth bulge”;
• A lower rate of population growth can facilitate the provision of basic social services in health, education and housing;
• A lower rate of population growth can help countries achieve long-term food security;
• A lower rate of population growth can help countries achieve sustainable development by protecting the natural resource base.

Research Knowledge Contribution: This analysis will help conference participants understand best practices for packaging population and development arguments for use in policy dialogue with leadership groups.

A09: 4
Global Resources Required for Family Planning Programs in Low- and Middle-Income Countries
John Stover
Futures Institute, United States of America; JStover@FuturesInstitute.org

Background/Significance

During the 1980s, a large number of research studies were conducted on the costs of family planning programs. That information was used by several researchers to prepare estimates of the financing needed globally to support family planning programs. Since then, however, very little new information on the costs of family planning has been collected. Recent information on the funding required for family planning commodities has been published, but no recent estimates of the global financing requirements have been produced.

Research: State main question/hypothesis Program: State intervention/activity tested

This study seeks to fill a crucial gap in the evidence base to support improved advocacy and resource planning for family planning programs. The main question posed is: What financial resources will be required in the future to support family planning programs in low- and middle-income countries?

Methodology (including location, setting, period, analysis approach)

We conducted a literature review of reports on the costs of family planning service delivery by country, method, and delivery channel. Since most of that information is from the 1980s and early 1990s, we collected updated information on the costs of service delivery in four countries: Jordan, Mali, Kenya, and Ethiopia in 2008 and 2009. We have used that information to prepare updated estimates of the cost per acceptor or per user by method, delivery mechanism, and region.

We have estimated the number of family planning acceptors and users by country, method, and delivery channel from demographic data from the United Nations Population Division and national household surveys. Estimates and projections of the number of women of reproductive age are taken from the 2008 round of estimates and projections prepared by the United Nations Population Division. Current levels of contraceptive use and unmet need for contraception are based on the most recent DHS and other national household surveys. We also analyzed the annual rates of change in contraceptive use between two surveys for all countries with more than one national survey. We developed several alternate projections of future contraceptive use by country through 2020 based on different assumptions about continuing past rates of growth and expanded efforts to increase past growth rates in countries with low levels of contraceptive use today.

Using data on method mix from national household surveys we estimated patterns of changes in method mix as contraceptive use rises. Countries with low contraceptive prevalence rates (CPRs) generally have high levels of traditional method use. As CPR increases, use of traditional methods declines and hormonal methods increase. At higher levels of CPR, the use of long-acting and permanent methods increases. We developed two typical patterns—one for Muslim countries where intrauterine device (IUD) use dominates at high levels of CPR, and one for non-Muslim countries where sterilization dominates at high levels of CPR.

We combined information on numbers of women of reproductive age, alternative scenarios of CPR increase, and method mix patterns to project the number of family planning users and acceptors by country and method. Information on pattern of service delivery by channel (public, NGO, private sector) was added to estimate the source of services. This information was added to unit costs of service delivery to project the total financing required by country, method, and delivery channel. We also made estimates of the distribution of current financing for public and NGO services between national and international sources to project total requirements for national and donor financing.

To the costs of service delivery, we will add the support costs to address key barriers to family planning expansion including policy and advocacy, communications, operations research, logistics and training.

Data: Data collection methods are described above.

Findings

The study will be completed by September 2009. The results will show the total financing required from donors and national sources to support the expansion of family planning services in low- and middle-income countries. Preliminary projections show that the number of modern method users is expected to increase to 210-250 million by 2020. Donor financing for contraceptive supplies alone needs to increase from about $220 million today to $400-450 million by 2020 to support expansion of family planning programs.

Research knowledge contribution

With the emergence of other health and development priorities, family planning programs have experienced waning government and donor support. However, continued support for family planning is needed, especially as countries grapple with continued rapid population growth and the challenges of meeting national health and development goals. Family planning advocates and programmers are in need of evidence to help make the case for renewed commitment to and additional resources for family planning. The findings from this study will help governments, donors, and advocates understand the global resources needed to expand access to family planning.

B09: Leading and Managing for Results in FP

Time: Wednesday, 18 November 2009: 10:30am - 11:45am

B09: 1

Makerere University's Investment in Pre-service Action-Oriented Leadership and Management Training: What are the Lessons for Family Planning?

Morsi Mansour1, Stephen Kijjambu2
1Management Sciences for Health (MSH), United States of America; 2Dean of School of Medicine, Makerere University, College of Health Sciences; mmansour@msh.org

Background/Significance

Recent global health initiatives—such as PEPFAR, the Global Fund, and the Gates Foundation—have proven beyond any doubt that low-cost interventions can reach large numbers of people and save many lives, but most interventions have not been scaled up to the extent possible. Both public and private sector managers and clinical and public health practitioners need to learn while in the university how to effectively manage and lead teams to achieve measurable results, especially in critical areas such as family planning. According to a 2005 WHO Working Paper, “The lack of ‘managerial capacity’ at all levels of the health system is increasingly cited as a ‘binding constraint’ to scaling up services and achieving the Millennium Development Goals.” One promising vehicle for scaling
up proven public health practices is integrating action oriented management and leadership development into pre-service programs. Results in several countries indicate that the Leadership Development Program (LDP) is an effective mechanism to improve family planning services for in-service settings. Lessons learned in these settings are being applied to student’s learning experiences at Makerere University School of Medicine and School of Public Health in order to scale up leadership and management capacity among students, faculty and service delivery sites to address public health challenges. This program provides lessons for revamping family planning by engaging clinicians, health managers and public health leaders in the pre-service setting to work in teams to improve health services.

Program: intervention/activity tested

The Community Based Education and Service approach at Makerere University, School of Medicine (COBES) requires each medical student to spend one to two months a year working at a community health site (COBES site). There was shared recognition by stakeholders at Makerere School of Medicine that the LDP was ideally suited to fill a gap in the training of medical students participating in COBES to equip them with the knowledge, skills and attitudes essential to face the leadership and management challenges they will encounter after graduation. In the COBES/LDP Program students experience firsthand the health challenges in their communities, and work with health staff in teams to find ways to address them. The integrated COBES/LDP curriculum consists of four modules that can be used in different ways. The four modules can be conducted in one or two years spread over a four year undergraduate medical curriculum. The first module focuses on scanning, the second on focusing, the third on planning, aligning, and mobilizing resources, and the fourth about monitoring/evaluation and inspiring. Both public and private sector managers and clinical and public health practitioners learn, from the beginning of their training, how to effectively mobilize teams to achieve measurable results. Students use the Challenge Model to lead others in effective public health interventions in low resource, health service settings.

Methodology (including location, setting, period, analysis approach)

In 2006, Management Sciences for Health (MSH) collaborated with the Makerere School of Medicine to integrate MSH’s Leadership Development Program (LDP) into the COBES program. A pilot was undertaken in two sequential modules in Jan 2007. The pilot involved 31 staff drawn from Makerere School of Medicine faculty and support staff; students and health workers from Ndeje Health Center and St. Stephen Rural Hospital (COBES sites), as well as observers from Makerere SPH and Muhimbili School SPH (Tanzania) to learn about the LDP.

Findings

The impact of the LDP/COBES initiative on service delivery can be assessed with respect to the 2 sites that participated in the pilot project and the effect on faculty and students of participating in an action oriented approach to leadership development. One health center increased the % of deliveries in the health facility of women seen for prenatal care from 15% to 50% in 6 months (baseline: average 24 deliveries in a month) and the other health center increase deliveries at the health facility by an average of 4 per month over 6 months. A follow up independent evaluation of the program in June 2008 revealed that FOM faculty members and administrative staff reported having found the LDP experience extremely valuable and are taking steps to integrate it into the curriculum of the School of Medicine.

Program: Lessons learned

The lesson from the COBES/LDP Program for family planning is that pre-service leadership and management development can help scale up proven public health practices, including family planning and other interventions to achieve the MDGs. Programs to improve clinical skills of pre-service health workers in family planning and reproductive health should consider adding the important component of leadership and management. When we equip students with essential leading and managing practices we enable them to work in an empowered way with health workers in the field to scale up proven practices to improve the health of the communities they serve.

B09: 2

Improving leadership and management at the front line to scale up and accelerate family planning results

Joan Mansour1, Juliana Bantambya2

1Management Sciences for Health, United States of America; 2EngenderHealth /ACQUIRE, Tanzania; jmansour@msh.org

Background/Significance

Despite years of investment in clinical skills training for providers of family planning and reproductive health services (FP/RH), there remains a profound gap between knowledge and performance. In January 2006 the Leadership, Management and Sustainability Program (LMS) of Management Sciences for Health, in collaboration with the USAID-funded EngenderHealth/ACQUIRE Project and the Tanzania Ministry of Health (MOH), initiated a six-month Leadership Development Program (LDP) in Kigoma, a remote rural province in western Tanzania. The aim of the collaboration was to integrate leadership and management development into ongoing technical assistance in an ACQUIRE-led family planning program in order to revitalize FP in the region and ultimately improve maternal and child health through performance improvement at the service delivery level.

Program: intervention/activity tested

Management Sciences for Health (MSH) has applied its Leadership Development Program (LDP) in 29 countries across the developing world and is demonstrating significant evidence of its contribution to improvements in FP/RH outcomes. The ACQUIRE Project wanted to explore the value-added of integrating a practical, action-based learning approach, as used in the LDP, to help teams strengthen leading and managing skills and work together to address service delivery challenges and achieve results. The core of the LDP is the Challenge Model, a simple tool that enables teams to take a systematic look at how to produce desired measurable results. Individuals work in teams on real workplace challenges, create an inspiring shared vision, scan data to document the current situation and obstacles and priority actions to address them, and prepare an action plan to achieve their desired measurable results. Participants go through four 2-3 day workshops over a 4-6 month period, during which, they conduct on-site team meetings, and receive feedback and support from facilitators and local managers.

Methodology

MOH staff from six health facility teams and three district teams participated in the program delivered in Swahili between March and June 2006. In addition to the 3 workshops, Kigoma ACQUIRE and district level MOH staff provided follow-up coaching to the teams to facilitate the application of the leadership and management skills learned and to refine their action plans.

Early in the LDP, teams were asked to review their family planning data to assess service delivery weaknesses and strengths. Originally of the opinion that they were performing relatively well, participants realized that they were achieving only modest results vis-à-vis family planning utilization. District teams acknowledged that health centers were under-performing, in part due to poor coordination between the district and their health centers, resulting in health center staff feeling isolated and unsupported.
Findings
The participating teams successfully used the tools introduced in the program, including the priority matrix to engage stakeholders and to identify priority activities, action planning, resource mobilization, and monitoring and evaluation (M&E) planning. As a direct result of their data analysis, teams reallocated health personnel to ensure adequate human resources were available for family planning counseling and service delivery; mobilized resources, including transportation for outreach services; provided new and refresher training for FP providers; and raised awareness in the communities about the importance of family planning for the health of women and children.

All of the teams selected the challenge of increasing the number of new family planning clients attending their clinics. As of December 2006, one year after the first LDP workshop, the monthly average of new family planning clients had increased in all nine participating health facilities from 2% to as much as 80%, with an overall average increase of 37%. The lowest performing facilities suffered contraceptive stock-outs due to a lack of transport.

In Kigoma, rather than implement an action plan directly, the District Council replicated the LDP workshops in five small dispensaries. Even at this basic level in the health system, four of the dispensaries, were able to increase new family planning visits by 33% to 53% from 2005 to 2006.

Program: Lessons Learned
These impressive results have motivated the Kigoma LDP facilitators from ACQUIRE and the MOH to independently scale up the program to an additional 20 dispensaries and health centers. As a first step, they held a workshop in October 2006 to empower lower level staff and equip them with leadership and management skills to strengthen health service delivery. This has led to an increase in the average number of new family planning clients per month by 33% in health centers/district hospitals and 62% in dispensaries. The ACQUIRE Project, LMS Program and MOH facilitators demonstrated that integrating the LDP into a service delivery project was effective in improving the performance of its health units.

B09: 3
Developing a Framework and Approach for Measuring Success in Repositioning Family Planning
R. Scott Moreland, Nicole R Judice
Futures group, United States of America; smoreland@futuresgroup.com

1. Background
In the past several years donors and their partners have renewed initiatives to ensure that family planning remains a priority in an environment of high levels of funding for other global health programs such as HIV/AIDS and malaria. These are often described as efforts to “reposition family planning.” Many tools and approaches have been developed in the research, policy, contraceptive service and health services delivery arenas to improve family planning use and countries are in various stages of repositioning family planning, but there is a gap in the ability of countries to assess the success of efforts to reposition family planning.

2. Methodology
This paper describes an on-going effort to develop a framework by which countries and programs can easily assess and evaluate the progress toward repositioning family planning. The effort involved relevant stakeholders, including donor offices and bureaus, and donor-funded program implementers to build consensus around an approach to monitoring and evaluating these repositioning efforts. The framework relates family planning program and project activities and inputs to outputs and impacts. A series of indicators and indices that were developed that allow measuring the extent by which family planning has been repositioned in a country. In developing the indicators and indices, an effort was made to maximize the use of existing data so that no special research study would be required to implement the approach.

3. Knowledge Contribution
The framework and M&E approach for Repositioning Family Planning can be used by international donors, governments and programs to assess their efforts, identify gaps in strategies to reposition family planning in countries, and use this information to inform funding, program design, policy and advocacy, and program planning and improvement. As the framework has not yet been adequately tested no results or lessons learned are available as yet.

B09: 4
Scaling Up Proven Public Health Interventions through a Locally Owned and Sustained Leadership Development Program in Rural Upper Egypt
Abdo Hasan El Swasy
Ministry of Health and Population, Egypt; abdo_alswasy@hotmail.com

Problem: In 2003 the Egypt Ministry of Health and Population (MOHP) faced the challenge of improving access to and quality of services in rural Upper Egypt in the face of low morale among health workers and managers.

Local setting: From 1992 to 2000, the MOHP, with donor support, succeeded in reducing the nationwide maternal mortality ratio (MMR) by 52%. Nevertheless, a gap remained between urban and rural areas.

Relevant changes: In 2002 the MOHP, with funding from the US Agency for International Development, introduced a Leadership Development Program in Aswan Governorate. The program aimed to improve health services in three districts by increasing managers’ ability to create high-performing teams and lead them to achieve results.

The program introduced leading and managing practices and a methodology for identifying and addressing service delivery challenges. Ten teams of health workers participated. In 2003 the districts of Aswan, Daraw, and Kom Ombo increased the number of new family planning visits by 36%, 68%, and 20%, respectively. The number of prenatal and postpartum visits also rose.

After USAID funding ended, local doctors and nurses scaled up the program to 184 health care facilities (training more than 1000 health workers). From 2006 to 2007, The LDP program participants in Aswan Governorate focused on reducing the MMR as their annual goal. They reduced the MMR from 50.0 per 100,000 live births to 35.5 per 100,000. The reduction in MMR was much greater than rates in similar governorates in Egypt. Managers and teams across Aswan demonstrated their ability to scale up effective public health interventions through their increased commitment and ownership of service challenges.

Lessons learned: When teams learn and apply empowering leading and managing practices they can transform the way they work together and develop their own solutions to complex public health challenges. Committed health teams can use local resources to scale up effective public health interventions.

C09: Access to RH Essential Medicines and Commodities: The Missing Link to Improving RH

Time: Wednesday, 18 November 2009: 10:30am - 11:45am
C09: 1

Expanding Global Access to Emergency Contraception: Challenges and Lessons from the Public and Private Sector

Elizabeth Westley

International Consortium for Emergency Contraception, United States of America; ewestley@fcimail.org

Background/Significance: Emergency Contraception (EC), a simple dose of oral contraceptive pills formulated to be taken after unprotected sexual intercourse has occurred, provides a second chance to avoid pregnancy for women who have not used contraception, and is especially valuable in settings with high rates of rape and sexual coercion, such as refugee camps and settlements of internally displaced persons (IDPs). This unique contraceptive method was all but unknown in the mid-1990s, but following extensive efforts by NGOs and manufacturers, a dedicated EC product has been registered in most countries of the world, and is available over the counter in many countries. EC introduction can provide useful lessons about the introduction of new essential medicines, especially those that have the potential for both public and private sector distribution.

Program Strategy: Beginning in 1996, the International Consortium for EC (ICEC) launched a multi-pronged strategy to expand access to EC, beginning with identifying the best regimen, and negotiating with a pharmaceutical company to manufacture, package, and register a dedicated EC product. A strategic introduction was then undertaken in selected pilot countries and globally to put EC “on the map.” One initial key step was ensuring inclusion in WHO’s Essential Medicines list as well as the lists of individual countries, developing generic training and information materials, and working with governments and local organizations to introduce the product. The effort was multi-pronged, as EC access depends on a number of institutional, regulatory, legal, political, distribution, and knowledge factors: knowledge that the method exists (which can be influenced through health worker outreach, advertising, peer education, etc), regulatory issues, including whether EC is available over the counter (OTC) or only by prescription or directly from clinicians, and policies either favorable or opposing access.

Results of the Consortium’s early efforts were mixed and in many countries the introduction took longer, and met with more opposition, than anticipated. However, over time the private sector saw the potential for EC and became increasingly committed to marketing it.

Data and findings: Introduction efforts and set-backs in key countries will be described, and data from Demographic and Health Survey (DHS) surveys will be summarized to provide a global picture of access. These data indicate that knowledge is surprisingly low in most developing countries, rarely rising above 10%, especially in Africa. Ever use of EC is even lower, averaging about 2%. As well, sales figures from social marketing organizations will be shared. Because of the high risk of rape and sexual coercion in these settings, special attention will be given to settings serving refugees and internally displaced persons (IDPs). Surveys conducted by UNHCR and other organizations in refugee camps indicate that the majority of camp settings do not offer EC in a timely fashion. Legal or policy opposition to EC has occurred in numerous countries, particularly in Latin America. Such opposition may increase awareness of the method, or it may render dedicated EC products completely or largely unavailable. Access through the private sectors and through pharmacies/drug sellers seems to be growing and is preferred by women. However, it raises new challenges. Quality assurance issues are of increasing concern, as “leaked” or counterfeit medicines are increasingly prevalent. In addition, women are less likely to receive accurate information, linkages with other services, and more general family planning and reproductive health advice.

Lessons learned: Because early EC access efforts were very much focused on registration of a dedicated product – a goal that has been largely achieved - there may be a sense among some in the family planning/reproductive health community that EC introduction has been achieved and that significant further investments are not called for. A closer examination of the evidence shows that access is much lower than registration data suggest. Our metrics of success have been too limited to provide an accurate picture of access for a full range of women, including the poor, those in rural settings, and women in crises settings; a careful, multi-faceted examination of access is timely and important. EC provides a useful lens to analyze the multiple factors that enhance or restrict access to family planning methods and other essential medicines.

C09: 2

Policy and Advocacy Initiatives for Reproductive Health Commodity Security

Jotham Musinguzi

Partners in Population and Development Africa Regional Office, Uganda; jmusinguzi@ppdsec.org

Reproductive health commodity security (RHCS) exists when every person is able to choose, obtain, and use quality contraceptives and other essential reproductive health products whenever they need them.

The concept of commodity security came about from a growing realization that to address reproductive health issues comprehensively, there is need for a strong supply chain that ensures availability of and access to reproductive health commodities. Also required are strong national leadership, adequate funding, supportive and enabling policies and regulations, proper coordination of key stakeholders as well as adequate service delivery. To ensure this enabling environment, a well-functioning supply chain requires strong and continued advocacy.

In Uganda, Partners in Population and Development Africa Regional Office and other partners including Civil Society Organizations have undertaken initiatives that support the enabling environment for commodity security, including a comprehensive framework for commodity security, establishing and supporting commodity security committees and advocating for financial resources to fund essential health commodities. This needs to link and to be supported by partners and networks at regional and global levels.

Primary target for the advocacy efforts:

1. Parliamentarians
2. Women Reproductive Health Champions as well as Goodwill Ambassadors of Safe Motherhood such as the First Lady of the Republic of Uganda, Hon. Janet Museveni and the Queen of Buganda Kingdom, Her Royal Highness, Sylvia Nagginda.
3. Civil Society Organizations
4. Leaders of Cultural and Faith Based Institutions
5. Professional Societies such as Uganda Medical Association as well as specialized agencies such as National Medical Stores
6. The media fraternity

Lessons learnt
- It makes a difference to involve policy makers in Reproductive Health Commodity Security
- Adequate skills are needed to do advocacy that creates change
• There is need to invest time and money for meaningful advocacy

C09: 3
Public Private Partnerships in Supply Chain Management: Lessons for Family Planning Programs
Alexis Heatson1, Christine Fullmer3
1John Snow, Inc., United States of America; 2PHD, a division of the Fuel Group; aheaton@jsl.com

Background/Significance
As family planning programs expand, Ministries of Health in developing countries often find themselves investing increasing amounts of scarce resources in supply chain management for the public sector as the number of health supplies and suppliers increase, order volumes swell, service delivery points expand, and customer demand grows. This growth in number of products and family planning clients results in expanding needs for warehousing, information management, transportation, and all of the equipment and staff needed to support those functions. Often this increased demand for resources occurs within an atmosphere of uncertainty as donor commitments and government budgets vary from year to year, seasonal disease patterns and product demand change, and fuel costs and currency values fluctuate, making this ostensibly “ancillary” responsibility of logistics management a significant part of an MOH’s management burden.

In recent years, the private for-profit commercial sector in many countries has evolved in response to similar demands. There has been an increase in the number of private sector companies and organizations expanding the use of third party service providers for functions that fall outside of their core capacities. Experience in the private sector has shown that rather than invest the additional resources in staff and infrastructure needed to expand support of these “external” functions within a company, it is often more efficient and cost effective to outsource to an organization that specializes in these services, often at a lower cost and/or higher level of service. Given the situation facing many governments and public health systems, organizations in developing countries have begun to explore how the same principle used by the private sector can be applied to public health supply chains to reduce costs and/or improve service levels.

Research: Main question/hypothesis
Contraceptive security is guaranteed by having the right product in the right quality at the right time in the right quantity to the right place at the right cost. This is, for a number of reasons, a significant challenge for the public health sector of many countries, because of difficulties identifying and maintaining the resources required to meet all of these six rights on a consistent basis. This may be due to increased supply chain demands of other programs, vehicle limitations, budget constraints, outdated information systems, policy shifts, or many other factors that governments face. For that reason, public private partnerships between governments and private companies for logistics have emerged as a potential way to maximize the resources of governments (MOHs) while leveraging the expertise of private sector service providers to better meet customer needs.

This study explores how the engagement of private sector logistics firms can help governments improve contraceptive security in the public sector by increasing efficiency in the warehousing, delivery, and logistics management and therefore improve access to family planning services. We look to examples from private organizations currently providing services to the public sector, as well as public sector clients to discuss their experiences and learnings from these partnerships.

Methodology (including location, setting, period, analysis approach)
This research included a desk based review of current examples of instances where public health supply chains are leveraging private sector providers to source some of their logistics functions and explores how these public private partnerships have affected service delivery. This included background research on current private sector practices in outsourcing and what public health sector organizations should consider when thinking about outsourcing some or all of their logistics functions and how this type of relationship might affect their ability to meet customer needs and contraceptive availability. Where possible, both the public and private partners were interviewed to provide insight to successes, challenges, or risks they experienced through these relationships.

Findings
There has been limited use of public private partnerships by governments to improve family planning and public health supply chain management in developing countries. Existing examples are largely from HIV/AIDS programs (often donor-funded) and primarily anecdotal. Objective documentation or analysis of how these partnerships affect service delivery or cost effectiveness has been limited. However, based on a few examples, some basic conclusions can be made with moderate confidence. The application of outsourcing and use of third party logistics (3PL) services to public institutions and specifically, public health systems, has the potential to improve service delivery, but is not always a natural or easy to implement solution.

Research: Knowledge contribution
There are many reasons why Ministries of Health and associated parastatal organizations responsible for warehousing and distribution of health products might want to consider outsourcing some of their supply chain functions to private contractors. However, shifting logistics functions in a supply chain to a 3PL is not always a certain success. This analysis identifies that there are many factors which should be considered on an operation by operation basis to determine whether there is an opportunity for improvement via outsourcing logistics functions. Further research and objective analysis of the health and economic consequences of third party logistics providers is needed to provide guidance for governments considering when and how to engage the private sector to improve supply chain management of family planning and public health products.

C09: 4
UNFPA-WHO Collaborative Initiative to Review the Current Status of Access to a Core Set of Critical, Life-Saving Maternal/Reproductive Health Medicines in Selected Countries (Laos, Nepal, Philippines, Mongolia, & Ethiopia)
Ahmed Kabir1, Helene Moller2
1UNFPA; 2WHO/Geneva; kahmed@unfpa.org

Background
In an effort to improve access to quality essential Reproductive Health medicines and medical devices, WHO, UNFPA and partners in the Reproductive Health Supply Coalition (RHSC) are engaged in a series of activities aimed at promoting harmonized global standards and technical assistance. These include developing guidance on sourcing good quality suppliers and products, building procurement capacity in resource-limited countries, and removing barriers to the appropriate use of these products. The purpose of this collaborative initiative was to present a “snapshot” of the current status of access to medicines for Maternal and Newborn Health Care and Reproductive Health, which are not routinely monitored. The findings of these joint exercises are intended to supplement the findings of other on-going studies and studies planned for the very near future. The six critical RH medicines chosen for these studies (varies on country contexts and priorities) were Oxytocin
injection, Ergometrine injection, Magnesium Sulphate injection and three antibiotics, Ampicillin injection, Gentamicin injection and Metronidazole injection.

These medicines were chosen because they are the WHO recommended medicines for the prevention and management of the three major causes of Maternal Mortality.

As a mechanism for preventing unwanted and unplanned pregnancies, FP reduces maternal and infant deaths. In addition to the above critical RH medicines, on the request of the DOH and with consideration of the falling CPR and the slowing reduction of the maternal mortality ratio (MMR) in the Philippines, the study made an effort to look into the need & demand, use, procurement & supply of one temporary method of: Family Planning (Medroxy-progesterone or DMPA Injections, 3 and 1-month formulations)

As the procurement and supply chain management for essential medicines and family planning commodities are interlinked in most countries, these assessments can also take into consideration to look at certain elements for the contraceptives procurement, quality and supply chain issues.

The main objectives of these assessments were to conduct a pragmatic exploratory study to:

1. Obtain a snapshot of the current status of access, supply and rational use of these selected life saving maternal/RH medicines
2. To develop a harmonized approach for performing rapid assessments of quality, usage and accessibility of essential medicines for RH
3. To guide Institutional support and capacity building in the areas RH commodities security.
4. Suggest ways forward for consideration by MOH and Key Stakeholders.

Methodology

Information required for the studies were obtained through document reviews, key informant interviews, and selected site visits for the purposes of tracking the need, demand and supply of the tracer medicines through the supply system to the point of use. A simple tool developed jointly by WHO and UNFPA is adapted in country context. Field visits are conducted at different levels (central, provincial, districts/sub-districts, and below) in selected service delivery facilities and pharmacies-both in public/govt. and private/NGO sectors. Areas that are covered, specific to the country specific tracer medicines are: (1) Need and demand; (2) availability; (3) essential medicine lists; (4) standard treatment guidelines and protocols; (5) rational use; (6) registration and certain areas of quality assurance; (7) storage; (8) procurement and supply chain; (9) costs and (10) coordination.

The assessment exercises at the country levels are conducted jointly by a team with members from Govt. /MoH, UNFPA, WHO, and representatives from key partners. At the end of the assessment, the issues identified and suggested ways forwards were presented to the MoH and other key stakeholders/partners at a debriefing meeting.

Limitations and Strengths

These rapid assessment exercises aim to provide snapshots of the current situation in selected countries regarding the availability and use of the selected sample of life saving RH medicines in a pragmatic sample of health facilities and pharmacies at the various levels in a country. The facilities are selected purposely (in consultation with the govt/MoH and other in-country key partners) considering transport, human capacity and the time constraints of the assessment and also because they have not been included in recent/previous such assessments. Therefore, limitation of the assessment is that the findings may not be generalizable to health facilities and pharmacies throughout the country.

The strengths of the assessment are that it can be completed in a short time frame; it is relatively inexpensive; the findings can supplement other similar ongoing or planned studies; it can enable wider stakeholder involvement in collaboration with the MoH and the findings can be used for raising awareness among key stakeholders.

Conclusions

The findings from these ‘snap shot’ assessment exercises so far conducted in the selected countries (Laos, Nepal, Philippines, Mongolia and Ethiopia) revealed to be very powerful and created very strong awareness among the govt. policy makers and key stakeholders. Key actions in terms of immediate, mid term and long term interventions required have been suggested and well appreciated by the respective governments and other in-country partners. Also from the Philippines exercise, it has been revealed that such studies can also include selected contraceptives to review the status and suggest ways forward for a harmonized procurement and distribution system in the country.

The detailed presentation in the conference will share these findings and ways forward drawn from these country assessments.

D09: Promoting Access and Affordability of FP

Time: Wednesday, 18 November 2009: 10:30am - 11:45am

D09: 1

What type of programmes have been successful in increasing access of marginalized groups to FP/SRH?

Nuriye Ortayli

UNFPA, United States of America; ortayli@unfpa.org

Background/Significance

Inequities in health outcomes and in the use of health services have been increasingly documented during the last decade. In order to achieve MDGs and move forward development agenda is important to understand the causes of health sector inequalities and develop interventions to overcome.

Main Question

World Bank has long been working on documenting the policies that reduce inequities in use of health services and as a result in health outcomes. A number of policies have been assessed as successful in reducing inequities of poor.

Methodology

A number of interventions in low- and middle-income countries have been assessed and shown to decrease the inequities in use of services. Four of these interventions which have been effective in increasing the coverage of reproductive health services for the poor will be examined in this presentation. These programmes have been conducted in Brazil, Nepal, Cambodia and India.

Knowledge Contribution

It is possible to increase use of services by the poorest parts of the population using certain interventions, after assessing the local needs and conditions.
D09: 2

**Integrating Equity Goals and Approaches into Policies, Plans, and Agendas**

Wasunna Owino, Suneeta Sharma

Futures Group International, United States of America; ssharma@futuresgroup.com

**Background/Significance:**

Integrating equity goals and approaches in policies, plans, and agendas is a crucial part of the EQUITY Approach. Effective policies and programs in a number of developing countries have successfully reduced barriers to access to family planning services among the poor and provided the neediest a greater share of resources and benefits. Including family planning in social health insurance schemes, designing and implementing demand-side financing mechanisms, promoting targeted use of resources, and linking family planning to development agendas are some of the strategies that have been tried by countries to improve access to resources and services among the poor. No single approach can help address the issue of low access and use of family planning services among the poor. Carefully thought out, evidence-based, country-driven policies and strategies are needed to ensure that health benefits and resources reach the poor and those most in need.

**Intervention/activity tested:**

In efforts to address low levels of family planning use and to respond to the family planning and reproductive health (FP/RH) needs of poor women, we devised a two pronged strategy that does the following: (1) Integrate equity goals, approaches, and monitoring and evaluation indicators in national reproductive health policies, and (2) Links family planning to development programs and agendas. In this presentation, we will share examples from Kenya, Mali, and Rwanda.

**Methodology:**

We conducted an extensive review of existing health and population policies to assess their effectiveness in improving access to affordable and equitable access among the poor. It involved an assessment of reproductive policy goals, priorities, strategies, availability of resources, implementation, and monitoring and accountability in achieving pro-poor objectives. We conducted literature reviews, key informant interviews with policymakers and implementers, and focus group discussions with vulnerable population groups, including the poor. We conducted stakeholder analysis to understand the linkages, commitment, level of influence, and priorities of stakeholders.

We analyzed the existing financing schemes because in many settings user fees, informal payments, indirect payments, and the access cost imposed on poor groups (such as travel, lost wages, and child care) all play a role in blocking access to care. We organized evidence-based policy dialogue to sensitize policymakers and implementers to acknowledge the existence of unacceptable levels of inequity and the importance and urgency of addressing inequities in health care use and outcomes. We conducted advocacy campaigns to help leaders from different sectors understand their role in promoting health and equity issues, addressing selected policy gaps, and influencing policy reforms, especially those that relate to the poor and underserved populations. These efforts also involved strengthening multisectoral linkages and encouraging meaningful involvement of the poor in designing and implementing policies.

**Findings:**

Evidence-based policy dialogue and planning processes led to the incorporation of equity goals, pro-poor strategies, and equity-based monitoring and evaluation indicators in the national reproductive health policy and strategy in Kenya. Persistent advocacy facilitated the inclusion of family planning in the Poverty Reduction Strategy Papers (PRSP) in Mali. High-level policy dialogue using the RAPID Model led to the inclusion of family planning in Vision 2020 in Rwanda. In this presentation we share lessons of a country driven, systematic process of incorporating equity into policies, plans and development agendas.

**Lessons learned:**

There is growing evidence that pro-poor health policies, combined with political support, can result in substantial reductions in health inequalities by improving service access for the poor. Countries need to strategically integrate pro-poor interventions into their overall approach to achieve the social goals of reducing poverty, promoting equity, and ensuring access to quality health services for the poor. Depending on the country context, this may include a pro-poor intervention, the development and implementation of policies against gender bias, equitable allocation of resources, identification and removal of operational barriers to access among the poor, involvement of the poor in the planning and decision-making processes, and application of equity-based monitoring and evaluation indicators to assess the impact of different interventions on the poor. Implementation of the selected strategies is a multi-sectoral and multi-step process. It is important to regularly monitor progress using equity-based monitoring and evaluation indicators, establish accountability mechanisms, analyze unintended consequences, and take actions to address evolving problems.

D09: 3

**Community-Based Access to Injectable: Policy Changes around Task-Sharing**

Anthony Mbonye¹, Shawn Malarcher²

¹Uganda Ministry of Health; ²Consultant; akmbonye@yahoo.com

**Background/Significance**

Community-based provision of depot-medroxyprogesterone acetate (DMPA) was first implemented in Bangladesh more than 30 years ago. This innovation was not attempted in sub-Saharan Africa until 2003 when the Ministry of Health of Uganda agreed to conduct a pilot test. Results of the pilot test demonstrated that community-based provision of DMPA was safe, feasible, and acceptable. How policies relate to innovative health service delivery issues is often challenging. Some challenges identified are global norms, global guidelines, country experiences, and research findings.

**Program: Lessons Learned**

Experiences from Malawi, Madagascar, and Uganda will be described as illustrations of processes which take place at the national and sub-national levels.

The Ministry of Health of Uganda has agreed to expand the intervention slowly allowing non-governmental organizations to incorporate community-based provision of DMPA into their programs. Yet nearly six years after the pilot study began in 2003, the policies in Uganda with regard to community provision of DMPA remain unchanged.

The Madagascar experience illustrates a different approach. In 2000, the country launched an initiative to place family planning and demographic issues at the top of the development agenda. Numerous activities were initiated to strengthen the national family planning program and address the unmet need for family planning. Wanting to expand access to DMPA, the Ministry of Health of Family Planning and Social Protection (MCHHPS) included provision of DMPA among the services that could be offered by trained community-based workers when it updated the National Reproductive Health Norms and Procedures in 2006. Although experience from multiple countries has shown that CBO of DMPA is a safe, effective service delivery mechanism, there was limited evidence from...
Africa and no experience from Madagascar. Policymakers in Madagascar were interested in obtaining evidence that community-based provision of DMPA could be successfully integrated into community-based programs in Madagascar. In response, the MOHFPSP partnered with Family Health International (FHI), SantéNet, and Population Services International (PSI) to pilot-test the program's feasibility, safety, quality of service provision, effectiveness, and acceptability.

A total of 62 workers were trained in CBD provision of DMPA in November 2006 and by February 2007, 61 were confirmed by clinical supervisors to be competent to provide DMPA and were providing services. (One agent re-located for family reasons.) Post-intervention interviews with CBD agents to assess knowledge and reported practices indicated all were adequately competent to provide DMPA services. By August 2007, 1662 clients had accepted DMPA from CBD workers, 41% of whom were new or re-starting family planning users. Acceptability among clients was high. Of 303 randomly selected acceptors, all were satisfied with services, and nearly all said that they intended to return to the CBD worker for re-injection and that they would recommend CBD DMPA services to a friend. 96% of clients who were eligible for re-injection by the time of the interview had received it; all but one received re-injection from the CBD worker. Among clients interviewed 97% reported no problem with the injection site. Aspects of the CBD DMPA intervention requiring additional attention include CBD workers’ ability to apply the pregnancy checklist; assurance of commodity stocks at the district level; and the need to simplify and to standardize reporting procedures to heighten the completeness and accuracy of service statistics.

Community-based provision of family planning services in Malawi is one of the oldest and well-established programs in sub-Saharan Africa. In the late 1990s, attention and resources were diverted away from the family planning program and community-based workers to address other critical health issues, such as HIV/AIDS. Currently, the government is interested in revitalizing the community-based family planning program. As part of this new initiative, the government plans to incorporate provision of DMPA into the mix of methods available through community-based services. The policy was changed in 2008 to allow Health Surveillance Assistants to administer DMPA.

Research: Knowledge Contribution

CBD of DMPA can be successful. An influential champion needs to be part of the local stakeholder team to ensure that advocacy continues and that policies continue to be pushed forward in the midst of competing priorities; there especially needs to be support from both the medical and political community if a change of this magnitude is going to be successful. Communications need to remain open, obstacles identified and solutions brought forth. If questions or concerns remain, a visit to a site where a successful CBD of DMPA program is ongoing is a compelling response to address concerns.

D09: 4

Improving Access to and Affordability of Family Planning Services

Nancy McGirr, Shweta Sharma, Nidhi Chaudhary

Futures Group, United States of America; nmmcgirr@futuresgroup.com

1. Background/Significance

Despite progress, there remains an unacceptably high level of disparity between poor and rich in access to quality RH services and outcomes. The poor have low access to health services for a variety of reasons, including lack of knowledge, lack of power, inaccessibility to facilities that provide decent care by responsive health providers, and financial barriers associated with the direct and indirect costs of services. Informal fees and other costs, such as healthcare supplies and medicines not provided by the healthcare facility, transportation, under the table payments, and food and board, in many cases constitute prohibitive costs resulting in women foregoing family planning, antenatal care, and institutional delivery. Effective programs and interventions in many developing countries have successfully reduced some of these barriers to improve affordability to healthcare services among the poor and give the neediest a greater share of resources and benefits. Social health insurance, demand-side financing, and targeted use of resources are some of the strategies that have been tried by countries to improve access to resources and services among the poor.

2. Program: State intervention/activity tested

To the extent that use of FP/RCH services is lower than desired as a result of the high financial costs of obtaining services relative to other demands for household income, utilization may increase with the provision of coupons/vouchers for free/subsidized services (conditional transfer) and/or additional income to purchase services (unconditional transfer). Futures Group supported the design and testing of various voucher scheme models in three states (UP, Uttarakhand, and Jharkhand) in India.

3. Methodology (including location, setting, period, analysis approach)

The voucher scheme was designed and implemented in two rural blocks of Haridwar District in Uttarakhand (from May 2007 to March 2009). Haridwar is one of the poor-performance districts in terms of all reproductive health indicators in the state. It also has the largest concentration of poor families (40 percent) and low literacy rates. In both blocks, there are a large number of vacant positions in government health institutions resulting in poor quality service delivery and reduced access. Haridwar has a fast expanding private sector with more than 50 private hospitals in Roorkee and Haridwar towns alone. However, there are huge variations in the types of services provided, the quality of services, and costs. Under the voucher scheme, costs for services were negotiated, accreditation of hospitals was granted based on approved guidelines, quality assurance systems were introduced, and training provided to service providers on contraceptive technology updates, waste management, and client counseling. The types of services targeted covered by vouchers include: antenatal care (ANC), institutional deliveries, postnatal care (PNC), sterilizations, intrauterine contraceptive devices (IUCDs), condoms and pills, and infant care. Vouchers for each set of services were printed and distributed to clients through 376 community health volunteers, called accredited social health activists (ASHAs), who are recruited and trained by the health department. The Office of the Chief Medical Officer of Haridwar District acted as the voucher management agency for monitoring voucher implementation and making payments. To ensure quality of services, NGOs conduct medical audits and client satisfaction assessments.

4. Data

Contact authors for available data

5. Findings

The voucher system has created considerable demand for services among the poor. The government can use the private sector already available instead of investing financial resources in non-functional government infrastructures. Demand-side financing helps governments target resources to poor families instead of providing free services to all segments, which are largely used by those who can afford to pay. The voucher system and associated monitoring also help to improve service quality in the private sector, reduce costs of services, and foster uniform standards. The voucher system has demonstrated that the governments can directly address equity issues, increase affordability and access, and significantly improve the health status of poor women and children.

6. Program: State lessons learned
Introduction of a voucher scheme is a complex process. Its success depends on the preparatory work done; systems designed, tested, and implemented; and ability to forge linkages among multiple stakeholders. Mutual distrust between private and public health services providers is a major obstacle that needs to be addressed from the start. Utarrakhand’s voucher system, after two years of implementation, has been readily accepted by policymakers, service providers, and clients. As a result, the government has decided to scale up and implement the voucher scheme in five districts beginning in July 2009, which will cover nearly 60 percent of the total rural poor population in the state.

In this presentation, we will also highlight some recent examples of designing and implementing targeting and innovative financing mechanisms to remove financial barriers to FP access in Africa and LAC.

E09: Working Together to Integrate FP into Other Essential Services

Time: Wednesday, 18 November 2009: 10:30am - 11:45am

E09: 1

Sexual Reproductive Health and Rights (SRH&R), HIV/AIDS Linkages and Integration Study in Uganda

Olive Sentumbwe Mugisa1, Rita Nalwada1, Rosemary Kindyomunda1, Dr. Esiru2, Collins Tusingirwe2, Beatrice Crahay3

1World Health Organisation, Uganda; 2UNFPA; 3Ministry of Health; sentumbweo@who.int

Background/Significance

Uganda’s HIV epidemic is severe, mature, generalized and heterogeneous, affecting different population sub-groups. The patterns of transmission of HIV are dynamic and change over time.

The Modes of transmission study (2008) indicated that, a total of 91,546 new infections (out of a total 15–49 year adult population of about 13.1 million) are estimated to have occurred in Uganda in 2008. The majority (43%) of these infections occurred among mutual monogamous heterosexual couples. There is clear evidence of deteriorating preventative sexual behaviours including increased multiple sexual partnerships, decrease in condom use at high risk sex among males and increase in number of young boys initiating sex before age 15. There is also a shift in the peak of the epidemic from young people 19-24 years to adults 30-38 years, coupled with high discordance levels of 5.4%

On the other hand, the high maternal infant mortality rates, high unmet need for family planning, high teenage pregnancy rates and the high STI prevalence rates are a reflection of challenges in addressing sexual and reproductive health (SRH) and rights of individuals. Heterosexual transmission accounts for about 76% of all new HIV infections and about 18-22% of new infection are through vertical transmission. These HIV transmission routes, accounting for more than 90% of all new infections underlie the interactions between HIV/AIDS and reproductive health. HIV/AIDS and reproductive ill-health have common root causes which include; socio-cultural factors, low social and economic status of females, and structural factors that limit accessibility to health and other basic social services. HIV/AIDS and SRH targets can only be fully met when individuals and sexual partners are informed and supported to enjoy healthy sexual lives and to make and act on positive SRH choices.

Government is aware that improvements can be made in meeting the reproductive health needs of people living with HIV and further reduce the incidence of new infections with HIV in the general population if quality integrated HIV/RH services are available to the general population.

Rationale

Prevention of HIV/AIDS and SRH ill-health targets can be more effectively and efficiently met when quality and equitable HIV/AIDS and SRH services are delivered in an integrated and sustainable manner which calls for strengthening of linkages between HIV/AIDS and SRH proactive policies, programs, and integrated service delivery. This means that problems such as the spread of HIV or poor reproductive health should not be addressed piecemeal but rather through joint efforts which therefore calls for delivery of a package of options.

The rapid assessment conducted by Ministry of Health Uganda in 2005 on SRH/HIV linkages and integration though not representative enough, highlighted the need for a RH/HIV strategy for better stakeholder coordination and collaboration. In addition, there is expressed need by HIV/AIDS/ RH programs for development of a broader national strategic framework to guide stakeholders engaged in policy/decision making, planning, and delivery of HIV/AIDS and SRH services. The new global tool on assessing HIV linkages and integration was used to carry out a more comprehensive assessment that highlighted key findings and recommendations.

Program: State intervention/activity tested

Application of the generic tool to generate evidence that informed the development of the RH/HIV strategy and operational workplan for scaling up integrated RH/HIV interventions at all levels.

Methodology (including location, setting, period, analysis approach)

The study was conducted in four districts of Gulu, Mayuge, Soroti and Kampala which were purposively selected. Soroti district was a pilot district for SRH/HIV services integration, Mayuge district was chosen because of its high concentration of high risk fishing communities, Gulu district until recently had a high proportion of its population living in internally displaced people camps and Kampala district because of its complexity and for being the host of the national and other major policy and decision makers in the country. The study was conducted for 4 months of June- September 2009.

Information and data was collected using the following qualitative and quantitative research methods: Documents review, In-depth Key informant interviews, Individual interviews (Exit interviews), Interviews of sexual partners of PHAs accessing services and Focus group discussion. The collected data was analyzed using statistical packages like SPSS.

Data (if relevant)

On-going results expected by end of September.

Findings

On-going results expected by end of September.

Program: State lessons learned

On-going results expected by end of September.

E09: 2
Kenya’s National Strategy on integrating RH and HIV: Main Features, Process followed in its development, Lessons Learned and Policy Implications
Margaret Gitau, Bartilol Kigen
National AIDS and STIs Control Programme (NASCOP) – Ministry of Health, Kenya; gitau@aidskenya.org

1. Background/Significance

The need to integrate Reproductive Health and HIV services is well articulated in many government documents. The justification for integration has also been explicitly argued in international literature and policy instruments: ICPD Programme of Action, the Maputo Plan of Action on Sexual and Reproductive Health and Rights, New York Call to Commitment, 2004 and Glion Call to Action, 2004 among others. It is widely recognized that linking reproductive health (RH) and HIV & AIDS policies, programs and services is of great importance to essential health care service delivery. First, clients seeking HIV related services and those seeking reproductive health services share common needs and concerns. Secondly, a stronger linkage between RH and HIV ensures that the RH needs and aspirations of those living with HIV are met. Thirdly, linking the RH and HIV policies, programs and services is an integral strategy in meeting Kenya’s National Health Sector Strategic Plans (NHSSP III) targets and the Millennium Development Goals and finally, having the two programs integrated provides the opportunity to leverage resources from either of the programs for the benefit of both the services.

Given the importance of providing integrated Reproductive Health and HIV services at service delivery level, the Ministry of Health in collaboration with its partners, embarked on the process of piloting out activities that could demonstrate the feasibility, acceptability and effectiveness of providing integrated services. The cumulative experience over the years from the initial pilot programmes and studies have been pulled together into a national RH and HIV Integration Strategy through a very elaborate process. It is the “How Kenya did it” that has motivated the authors (who have been at the fore front) in coordinating the Reproductive Health and HIV activities in the country to share these experiences with colleagues and policy makers working in similar settings.

2. Specific objectives

• To share background experiences on overall integration effort in Kenya
• To outline the main features of Kenya’s RH and HIV Integration strategy
• Describe the process followed in developing the RH and HIV Integration strategy
• Share lessons Learned
• Discuss the Policy implications of the process followed and lessons learnt

3. Methodology (including location, setting, period, analysis approach)

• Details of how the strategy was developed will be shared including explanations of how key divisions in the MOH coordinated other stakeholders
• Role of RH/HIV Integration committee (in terms of coordinating the implementation, of programmes, resource mobilization activities, support to advocacy campaigns, monitoring and evaluation of the implementation of programmes, review of existing policies and guidelines etc).
• Details of the design of integration effort will be shared (including how levels of integration were developed and the nature of services expected to be delivered by each level of care, essential packages, development of indicators among other details)

4. Results/lessons learned and expected contribution to programming and policy making process

• Although the effect or impact of implementing integrated services may not be obvious in the short term, process activities will be described and experiences shared. Description of relevant programmatic and policy issues will give an opportunity to other participants to reflect on what works, how it works and the broader steps to follow in implementing RH and HIV integrated activities.

E09: 3

Integrating Healthy Timing and Spacing of Pregnancy into Child Health Services in Rwanda: an essential child survival intervention
Issakha Diollo1, Gloria Ekpo2, Naomi Brill Skena3
1 Management Sciences for Health, United States of America; 2 BASICS; hakhter@msh.org

1. Background/Significance:

New findings from recent studies on birth spacing, most of them sponsored by USAID, provide evidence for what has long been observed—the spacing of pregnancies is crucial for child survival. As a result, Healthy Timing and Spacing of Pregnancy (HTSP) has now become an essential component of child health interventions and as such is integrated into the BASICS project’s scope of work. Indeed the research findings revealed that compared to 24 to 29 month birth intervals, 36 to 41 month intervals are associated with the following percentage reduction in risk: 26% reduction in neonatal deaths, 43% reduction in infant deaths, and 51% reduction in under-five deaths. Researchers therefore recommend that for the health of the mother and the baby couples who desire another pregnancy to wait at least 24 months, but not more than 5 years, after a live birth before becoming pregnant again. Using a family planning method during this interval is a good way to ensure adequate spacing. The analysis of the Rwanda 2005 DHS data revealed that in Rwanda 23% of women spaced less that 24 months and 41% spaced less than 36 months; only 36% have their birth to birth intervals equal or greater than 36 months. These data also showed that achieving birth intervals equal or greater than 36 months compared to birth intervals less than 24 months would be associated in Rwanda with an 80% reduction in neonatal deaths (70 vs. 24/1000), 39% reduction in post-neonatal deaths (79 vs. 48/1000), 36% reduction in child deaths (113 vs. 72/1000), 52% reduction in infant deaths (149 vs. 71/1000), and 44% reduction in under-five deaths. Under-five mortality would drop by nearly 11,000 each year if Rwandan women achieved their preferred birth intervals. The purpose of this presentation is to describe and discuss the BASICS project’s innovative strategies for HTSP integration to child health services, the major results achieved and lessons learned from its demonstration program in Rwanda.

2. Program interventions/activities:

BASICS used two interdependent and interrelated strategies for the integration of HTSP into routine newborn and child health programming and activities: An evidence-based advocacy PowerPoint presentation to create awareness and commitment for HTSP among target decision makers, and a detailed programmatic methodological guideline to orient step by step the integration of the HTSP educational messages and services into every routine child health service at facility and community levels and related tools: training manual, supervision checklist and job aids.

3. Methodology:
Implementing a Sustainable Integrated MCH/FP/RH Model

Nagwa Samir, Lynne Morin
Pathfinder International, Egypt; LMorin@takamol.org

1. Background/Significance: Family planning (FP), reproductive health (RH), and maternal and child health (MCH) activities in Egypt have attained significant success since the 1980s leading to a drop in the total fertility rate from 3.3 to 3.0 (births/woman); and an increase in the FP rate from 24.2% to 60.3%. The vertical service delivery system, however, misses several opportunities to deliver care. Even at health facility sites, there are separate rooms for each service, with separate staff, separate standards, training curricula, staffing patterns, information systems, supervisory tools, budgets, incentive systems, and a top-down management approach.

2. Program: State intervention/activity tested: The USAID-funded, Pathfinder International-managed Integrated Reproductive Health Services Project (Takamol) promotes an integrated model for strengthening MCH/FP/RH services. Takamol updated the national Standards of Practice to integrate MCH and RH services, which was incorporated into the MOH’s national curriculum. At the local level, the model provides clinical training on the delivery of quality MCH/FP/RH services such as proper antenatal care and IUD insertion. These trainings are strengthened by a strong interpersonal communication component that enhances providers’ counseling skills, especially dealing with rumors regarding the care of pregnant women and newborns and FP methods. This is extremely important in encouraging women to attend regular antenatal visits, and making informed choices regarding FP. Efficient counseling also addresses the discontinuation rate, which is high in Egypt. Service providers are trained to counsel women on breastfeeding, vaccination schedules, birth spacing, LAM, and FP during ANC. Management, supervision, and leadership training is given to primary health care (PHC) clinics and district teams. This gives actors at the facility and supervisory levels the tools, skills, and motivation needed to consistently monitor and improve performance.

Takamol developed an on the job-training (OJT) program that provides PHC staff with follow-up visits to reinforce the application of newly acquired knowledge in their “home” environments and encourages continuous quality improvement. MOH supervisors serve as coaches. OJT teams provide technical assistance based on specific staff needs as identified by the Integrated Supervision Quality Checklist. Some of the checklist topics include: counseling pregnant women who come in for ANC visits on birth spacing, FP methods, breastfeeding, LAM criteria, and asking women who come to vaccinate their children about their plans for FP.

3. Methodology The project targets its activities toward 200 PHC clinics and select poor urban areas in 11 governorates. Takamol monitors its interventions through indicators that compare baseline and post-intervention data. To assess the sustainability of interventions, Takamol reviews indicators and data collected by district teams from 15% of the project’s health facilities after it phases out.

4. Findings Fifteen months after Takamol phased-out of the area, results from seven clinics during January – March 2009 showed:
   - Couple years protection averaged a 30% increase over baseline;
   - New FP clients (under 30 years with up to 2 children) increased an average of 39.8% over baseline;
   - Quality of health services averaged 91% (The quality score is calculated according to a checklist serving as a proxy score to FP/MCH services, infection control practices, and administrative performance at the clinic level.);
   - Client satisfaction scores averaged 80%; and
   - FP and ANC caseloads increased an average of 51% and 21%, respectively, over baseline. These figures include both new and recurrent patients.

5. Program lessons learned
   - Policy and program attention is shifting towards integration where effective interventions build a comprehensive health system.
   - Integration is an opportunity to strengthen existing FP services. Integrated MCH/FP/RH services are better able to meet client needs by providing a package of services. Services reach more clients by using all opportunities for service delivery, requiring fewer provider-client contacts, e.g., women in MCH waiting rooms or in the postabortion period who receive BCC materials and information about FP.
   - There is broader cultural acceptability of FP when presented as a MCH service component.
   - Integrated services also lead to increased use of FP. In Takamol intervention clinics the increase in case load is coupled with an increase in FP use.
Addressing Gaps in Family Planning Education through Building the Capacity of Pre-service Tutors

Helen Lugina1, Sheilah Matinhure1, Nina Frankel2, Holley Stewart3
1East, Central and Southern African Health Community, Tanzania; 2Capacity Project; 3Africa’s Health in 2010; helugina@ecsa.or.tz

1. Background/Significance

As part of the effort to reposition family planning (FP) for sustained reduction of the unmet need in the context of the broader reproductive health service provision and the HIV/AIDS prevention and control programmes in Africa, the East, Central and Southern Africa Regional Health Community(ECSA-HC) with support from USAID/Africa Bureau, the Capacity Project, and Africa’s Health in 2010 Project decided to work to increase knowledge and teaching practices of midwifery tutors from three countries in the ECSA region on contemporary issues in family planning.

2. Research: State main question/hypothesis

Program: State intervention/activity tested
To train and mentor midwifery tutors on contemporary FP issues in order to update their knowledge and improve their skills for transferring information to nursing and midwifery students to improve quality of reproductive health care.

3. Methodology (including location, setting, period, analysis approach)

ECSA-HC, in collaboration with Capacity Project and Africa 2010, developed training materials through a process of adapting existing materials as well as creating new ones as needed. The materials were sent out for review by various experts and recommendations were incorporated. ECSA, Capacity Project and MOHSW Tanzania organized a one-week planning workshop where the materials were further reviewed and tools for pre/post test and evaluation were developed. The training methods included plenary presentations and discussions, small group work, games, quizzes, case studies and practical demonstrations. Prior to the training, a pre test was given and the same test was administered after the training. Participants also developed individual action plans on their selected elements of quality improvement, especially in family planning clinics where their students practice. They also developed country action plans on how to use the updated information and plan for its integration into their curricula. A second post test was given to the participants after 6 weeks and later qualitative follow up was done. For the qualitative follow-up, a questionnaire was administered, to which 20 of the 22 workshop participants responded through a combination of face-to-face interviews, telephone calls and emails. Additional qualitative information was gathered more informally via a listserv for participants and facilitators created after the workshop.

4. Data (if relevant)

Pretest scores, post test scores, follow up post test and qualitative interviews.

5. Findings

The results demonstrated that retention of the workshop information remained high three months after the workshop. The data show that the average score moved from 58% on the pretest to 81% on the post-test and remained at 81% for the re-administered post-test.

During the follow-up data collection, participants were asked about how they have utilized the information and resources they received in the training and any difficulties they have experienced in the application of the knowledge and skills gained. In general, the data confirm that the workshop was extremely successful, that the participants feel their work performance has been in enhanced and that they report significant satisfaction with the intervention.

With regard to the way participants have utilized the workshop information and resources, 61% reported that they have used the information/resources to update their protocols and curricula. For instance, a participant from the Ministry of Health (Human Resource Directorate) in Dar es Salaam, Tanzania explained, “We have already incorporated the contraceptive technology updates into the training curricula (Certificate and Diploma Nursing curricula), and we are also planning to update the Advanced Diploma and Degree Nursing curricula. Kilimanjaro Christian Medical College Faculty of Nursing at Tumaini University in Tanzania now includes family planning as unit in Advanced Nursing. The School of Nursing Muhimbili University of Health and Allied Sciences is also using the curriculum in its training. Huruma School of Nursing is adding FP to its curriculum in this year. Another outcome of the workshop is the development of a comprehensive Centre of FP Excellence, currently underway at the Kenya Medical Training College campus at Kitui.”

6. Research: State knowledge contribution

Program: State lessons learned
The lessons learnt from this activity are:

• There is a need for and interest in updates of FP information for midwifery tutors in east Africa

• Midwifery tutors improved their FP knowledge through participatory methods used at a training workshop and retained a large amount of this information three months later

• Midwifery tutors successfully integrated FP knowledge from the workshop into their courses/curricula, thereby improving the quality of the education received by their students

• Action plans created during the workshop to improve clinical practicum sites and other work settings were, to varying degrees, implemented, demonstrating the value of their inclusion in the workshop.

Introduction of Long Term Family Planning Methods to Address the Unmet Needs for Zambian Women

Bernard Kasawa

JHPIEGO Health Services and Systems Program, Zambia; kasawa2000@yahoo.com
Learning objectives: by the end of my presentation, the participants will be able to use some of the lessons learnt in the implementation of long term family planning (Jadelle implants) services in Zambia to enhance program activities in their countries.

1.0 Background

Zambia has a population of 10.9 million people. Women of reproductive age constitute 22% of the Population. According to DHS 2007, the Maternal Mortality Ratio (MMR) is 591/100,000 live births and use of modern contraceptive methods stands at 41% and unmet needs for married women at 27%. Zambia’s fertility rate stands at 6.2 children per woman. The unmet need for family planning is therefore quite high. The National Health Strategic plan 2006 – 2010 recognizes provision of FP as one key reproductive health strategic intervention that has the potential of contributing to the reduction of the maternal mortality. Ministry of Health in conjunction with Cooperating Partners identified long term FP (LTFP) as having both social and economic benefits that could impact positively and enhance the wellbeing and empowering the majority of women especially in rural communities. The objective is to promote the Long-term Family Planning methods in the expanded FP method mix for all women in Zambia.

2.0 Expanded contraceptive choice - Jadelle program in Zambia

The Ministry of Health in partnership with USAID funded Project (Health Services and Systems program – HSSP), UNFPA, UNICEF and WHO in 2004 took the up challenge to scale up Long Term Family Planning Methods. Society for Family Health (SFH) came on board and has intensified the promotion of intra uterine contraceptive device (IUCD) methods. Site assessments of health facilities were conducted in a way that would bring the service as close to the communities as possible more especially rural communities. 179 sites where covered in 42 districts out of 72. Capacity was built by training over 500 health care providers was done. IEC materials were produced targeting the community as well as some job aids for health care providers. Jadelle was procured by UNFPA and USAID. The aim is to have Jadelle implant FP services provided in 60% (43 districts) in Zambia by 2010. The program is still being rolled out to the remaining districts. Monitoring of the program is done through regular HMIS, follow-ups and technical support supervision.

3.0 Program results and challenges

3.1 Results;

Over 7000 inserts procured by UNFPA and USAID have been utilized. The demand for the Jadelle implant commodity increased with waiting lists almost at all facilities.

3.2 Challenges;

Commodity stock out and failure to meet the ever increasing demand, shortage of skilled manpower to provide the service, lack appropriate infrastructure and basic equipment and Ministry of Health over dependency on donors.

4.0 Lessons learnt;

• It is easier and quicker to reach out to as many clients in need of family planning services through focused pulling together of resources from all stake holders
• Long term family planning Jadelle implants is one of the most popular methods cherished by our women in Zambia

5.0 Conclusion

The high acceptance rate of the Jadelle implants and complete utilization of stocks has shown the success rate of the method. Government and Partners commitment to the purchase of the commodity will ensure more program success and sustainability leading to reduction of FP unmet needs of women in Zambia.

F09: 3

Introduction of two best practices in Madagascar: lessons learned about the implementation and analysis of the project

Jennifer I Wesson1, Tara Nutley2, Serge Raharison3, Mackenzie Green4, Ny Lova Rabenja3

1Family Health International; 2MEASURE Evaluation; 3Madagascar Ministry of Health and Family Planning; jwesson@fhi.org

Background/Significance

The population of Madagascar is due to double by 2030. Madagascar has a high fertility rate of 5.2 births per woman, 18% prevalence of use of modern methods of contraception and 24% unmet need for contraception. The Ministry of Health, Family Planning, International, and Santénet partnered in 2007 to design the Best Practices Package (BPP) Demonstration Project, which implemented two internationally-defined best practices: systematic screening and a checklist to rule out pregnancy.

Intervention tested

Systematic screening is designed to increase the number of services received during a client visit, resulting in integrated services and efficient use of client and provider time. In this intervention, providers screen each client for the need for essential services on a one-page screening form, regardless of what service the client originally sought. Based on World Health Organization criteria, the pregnancy checklist allows providers to determine with reasonable certainty that a client is not pregnant so that contraceptive services can be initiated in the absence of a pregnancy test. Research studies validating the checklist found that it is 99% correct 99% in determining if a woman is not pregnant.

The primary objectives of the study were to: document implementation of the BPP, identify obstacles and facilitators to inform scale-up, and examine changes in service utilization.

Methodology

The BPP was introduced in 15 facilities (primary and secondary care) in 3 districts of Madagascar. A total of 57 staff members were trained in implementing the best practices. During the training, each health facility created an action plan for the introduction of the BPP. These plans were used as supervision tools.

Following training and a six-month implementation period, managers, providers and clients were interviewed. Service utilization statistics were examined from one year prior to the intervention until six months after its introduction.

Findings

In total, six district supervisors, 44 providers and 1332 clients were interviewed. A simple difference between service utilization in the six-month period after the BPP intervention and the same six-month period in the previous year revealed an increase for nearly all the preventive services included on the systematic screening form (4% - 246%). However, a time trend analysis over 18 months revealed that there was already a tendency towards increased utilization before the introduction of the BPP. The BPP intervention itself did not appear to spur an increase of utilization beyond the trend already observed. It was not clear how systematically providers applied the screening tool; during the observation period, screening forms were completed for only 25% of the consultations.
Nevertheless, supervisors and providers nearly universally recommended the BPP. Supervisors, providers and clients expressed favorable opinions about systematic screening. Managers and providers thought that it helped them to achieve targets and work more effectively. 40% of clients reported that the provider talked to them about a service other than the need that provoked their visit. 95% of those clients liked the idea that the provider talked to them about other things and felt that this indicated a good quality of care. Although providers worried about keeping clients waiting too long with systematic screening, clients were almost equally as likely to say the wait time was shorter during the current visit (36%); the wait time was now longer (23%); or that the wait time was the same (18%).

Nearly half of providers (49%) said they used the pregnancy checklist very often, but 14% said they never used the checklist. Many providers had doubts about some of its assumptions, including whether clients are truthful (20%) or are able to remember or too shy (15%) to accurately report their behaviors. Half of providers thought that clients were only somewhat honest (47%) or not honest at all (3%) when responding to checklist questions.

Knowledge contribution
Several factors may explain why the BPP was not associated with increased service provision. The large number of interventions taking place concurrently in Madagascar may hide the effects of the relatively modest and low-cost BPP. In addition, given that systematic screening forms were completed for only one-quarter of consultations and the relatively low reports of pregnancy checklist use, it is difficult to determine the rate of provider compliance.

Although the implementation of the BPP did not result in hoped-for increases in service utilization, sentiments about this intervention remain positive. The BPP resulted in many facilities changing their service provision from a vertical to an integrated system. Based on advice from participants and lessons learned during implementation, the MOH plans to modify and scale-up the BPP. The BPP can be used to assist primary health care efforts to integrate services, and with improvements may also result in an increase in the uptake of services.

It is also important to note that simple pre- and post-intervention measures of service utilization may be deceiving if existing time trends are not taken into account.

A10: Improving FP Through Communication and Client Centered Care

Time: Wednesday, 18 November 2009: 11:45am - 1:00pm

A10: 1

Engaging Malian Religious Leaders on the Issue of Male Involvement in FP

Modibo Maiga1, Dr. Bieta Keita2
1Futures Group International, Mali, Health Policy Initiative; 2Malian Ministry of Health (DSR); mmaiga@futuresgroup.com

Background
Men in many cultures worldwide are key decisionmakers concerning family planning and reproductive health (FP/RH) within the household. All too often, however, the social expectations and responsibilities that define masculinities inhibit men from being interested and informed about crucial FP/RH issues. Programmatic research at the community level highlights the positive effects of engaging men as partners in women’s and men’s reproductive health. Interventions that target men have increased men’s awareness of and support for their partner’s reproductive health. Policymakers, healthcare providers, and donors have recognized the correlation between women’s and men’s gender roles and their reproductive health (Drennan, 1998).

National governments are beginning to focus on constructive men’s engagement (CME) in FP/RH. Yet this increased attention is occurring in the absence of an informed policy environment that encourages civil participation from influential community leaders. Religious leaders and faith-based organizations are often some of the most influential stakeholder groups within a country. In Mali where more than 95 percent of the population is Muslim, policymakers recognized the importance of involving Muslim leaders throughout the policy development process to produce meaningful CME guidelines. Integrating lessons learned from community-level interventions and involving community leaders in the policy development process is imperative to sustainably increase men’s and women’s uptake of FP/RH services.

In 2007, policymakers in Mali recognized that greater male involvement was needed to improve FP/RH indicators. At the time, the unmet FP need was 31.5% among married women, and the prevalence of modern contraceptives was 6.9% (DHS, 2006). Mali had an alarmingly high maternal mortality ratio at 464 maternal deaths per 100,000 live births, and the total fertility rate was also high at 6.6 children per woman. Gender inequities contributed to these health outcomes: among married women in Mali, ages 15–49, only 6% reported that they made health-related decisions together with their husband (IPS et al, 2006).

Program
Few efforts are focusing on the policy environment for men’s engagement. To help address this gap, the USAID Health Policy Initiative (HPI), Task Order 1, worked in cooperation with the Ministry of Health, Muslim leaders, and other partners in Mali to implement a model process for building an enabling policy and institutional environment for CME in FP/RH.

Methodology
HPI drew from a CME framework that encourages men to become more involved in FP/RH in the context of three overlapping roles: (1) as clients of RH services; (2) as supportive partners to women; and (3) as agents of change in the family and community (Greene, 2005). In November 2006, HPI conducted key informant interviews with representatives from the following organizations to assess the current environment related to gender, reproductive health, and CME: the Ministry of Health, Department of Reproductive Health, Parliament, USAID and its cooperating agencies, other donors, local NGOs, and Muslim leaders. Interviews also helped to identify policy champions. HPI led trainings to increase policy champions’ knowledge and awareness about gender, CME, and the links to FP/RH. HPI then facilitated an assembly of a multistakeholder group of stakeholders to inform, refine, and validate national CME guidelines; this assembly was called the National Consultation Meeting for CME. Adapting an informed, civil participatory model to policy development in Mali required securing ministry-level ownership to develop the CME guidelines and also the integral involvement of Muslim leaders to ensure community-level impact.

Findings
At the national level, in May 2008, the Ministry of Health adopted and integrated CME guidelines into the Mali’s Reproductive Health Strategic Plan. The Ministry of Health established an Advisory Committee to draft and refine the CME guidelines. The Advisory Committee administered these tasks while relying heavily on participants from the National Consultation Meeting. The Ministry-level support from the onset was essential. This support helped facilitate policy dialogue and keep the guidelines atop stakeholders’ agendas.

At the community-level, Muslim leaders are implementing the principles outlined in the CME guidelines. From their leadership positions, these religious leaders now stress the importance of men seeking health services for themselves, in support of their partners, and as agents of change within their communities.
Designing a Family Planning Campaign for Rural Women in Zambia

Uttara Bharath Kumar, Reuben K. Mbewe, Lynn Lederer, Faraz Naqvi

1Health Communication Partnership, Zambia; 2Ministry of Health, Zambia; uttarabk@hcp.org.zm

Name and Affiliation: Uttara Bharath Kumar (Health Communication Partnership Zambia), Dr. Reuben Kamoto Mbewe (Ministry of Health, Zambia)

Lynn Lederer, Faraz Naqvi (Health Communication Partnership Zambia),

Background/Significance: Fertility is high and increasing, especially in rural areas of Zambia - TFR of 7.5 (ZDHS 2007) up from 5.9 (ZDHS 2001/02). High unmet need for family planning (27% of all married women) persists. (2007 ZDHS). When asked about the last baby they had, 26% said they had not wanted any more children and 16% said they had wanted a child later, not then. So effectively for 42% of women, their last baby was unplanned. Access gaps include provider knowledge, skills, attitudes and workloads (MCH teams overloaded with under-five, family planning, antenatal and PMTCT services); contraceptive shortage, human resource, equipment and private space. Demand-side gaps include concerns regarding side effects of modern methods, limited awareness of method choice (what, where and when to access methods), and desire for large families, especially among men. The mean ideal family size is 5.3 children according to men compared to 4.7 for women (2007 ZDHS).

2007 found that method-related concerns are the second most common reason for NOT using FP (second to fertility related reasons.) These include fear of side effects, health concerns, belief that methods interfere with the body’s normal processes etc. Self efficacy of women to access modern family planning methods is low. Half Zambian women have had at least one child by the age of 19 (ZDHS 2007). Myths, misconceptions, traditional practices and beliefs that are perpetuated by traditional, religious and community groups and leaders. Gaps described above are exacerbated in rural areas.

- 74% of men and 59% of women listen to the radio and 37% of men and 31% of women watch television.
- Missed opportunities: six in ten men and women of ages 15-19 had not heard of family planning in the media.
- Where they did get information about family planning at all, radio was cited as the most important source of family planning information and television next

Intervention/Activity: There are certain significant determinants of behaviours that affect the update of modern family planning methods:

1. Perceived social norms around family planning use
2. Perceived efficacy and benefits of modern methods of family planning
3. Women’s self-efficacy to talk to partners about family planning about their own interest in using modern family planning methods

The need is much greater in rural women so under the Ministry of Health’s guidance, and technical input from cooperating partners, HCP is currently implementing a family planning campaign targeting rural women and their partners. Revitalize the national family planning logo to tie campaign materials together and raise public awareness of family planning.

Key objective of the campaign is to

1. Increase approval and use of modern family planning methods, especially in the rural areas.
2. Promote positive images of empowered women and supportive spouses

The goal of this campaign is to contribute to increases in modern contraceptive use among Zambian women, with a particular focus on underserved rural communities. We want those who are exposed to the campaign to move to the following behaviours:

Methodology: Multi-Media Approach

Given the increasing exposure of rural areas to television and radio (community radio in particular) will be key vehicles. Literacy is not high among rural women so pictorial and easy-to-read posters were developed for the clinic waiting rooms and community centres that serve as reminders about family planning. Community drama plays a key role in informing and engaging rural communities around health and social issues. Sample scripts provided ideas to existing, trained drama groups for performances. Materials developed included:

- 5000 health care provider buttons that say “Talk to me about Family Planning” with the FP logo
- 3 Television Spots (5 minutes each)
- 3 Radio Spots: (5 minutes each): Spots on TV and Radio in English + 7 Zambian languages (broadcast on ZNBC, community radio stations, other TV stations, ZANIS)
- Posters: Each of the three posters reflects the message from each of the three TV/Radio spots. Basic message on each poster translated into English + 7 Zambian languages
- Booklet: “Our Family, Our Choice” all-methods booklet

Findings: The campaign is in its initial stages and so far anecdotally very welcome in terms of information. The creative concepts for the campaign pre-tested very well.

Lessons learned: The absence of a mass media Next steps will include follow up with partners and distribution sites on the video’s impact. Include questions in the HCP end of project survey (2009) on exposure and look for statistically significant correlation to FP knowledge and behaviour.

A10: 3

Expanding Technical Capacity in Conflict Settings: Leverage Networks to Strengthen FP Programs

Katie Mary Anfinson, Stephanie Weber, Melissa Sharer

American Refugee Committee, United States of America; katea@archq.org
1. Background/Significance

Integrated comprehensive reproductive health (RH), including provision of strong family planning (FP) services, is not the norm in most current conflict settings. In many instances, there is a lack of trained providers in FP combined with a lack of FP options. With constant supply chain interruptions, lack of diverse methods available, and consistent low uptake among returning/refugee clients being the norm, these factors make providing reliable, high quality FP services a rarity in most crisis settings. The RAISE Initiative aims to reduce these barriers and helps position FP services in conflict situations to provide comprehensive FP, integrated with comprehensive RH services (e.g. EmOC, post abortion care (PAC), VCT, CMR). As a RAISE partner, the American Refugee Committee (ARC) is part of a network of providers, advocacy professionals, and technical specialists focused on RH and FP. ARC’s participation in RAISE has had many benefits, one being increased opportunities to be able to provide more consistent distance monitoring and on-site technical support by headquarters to field staff.

2. Program: State intervention/activity tested

A major component of ARC’s headquarters technical team is to provide TA to the field on all aspects of RH. However, given the high demand from the field for increased direct support and longer term on-site visits, ARC headquarters staff began exploring other professional avenues to find creative solutions to provide stronger levels of support for FP and RH. Guided by high levels of information sharing among RAISE partners, ARC was able to identify opportunities to innovatively better meet the RH and FP needs of IDPs in Darfur and for Congolese Refugees in Rwanda. ARC leveraged external support by collaborating with the Fellowship in Family Planning Program to find a technically qualified professional with field and management experience, and worked with two field sites to place this skilled FP Fellow in the field for six weeks. Essentially, ARC was able to scale up support to the field by using a proxy TA to provide on-site, technical capacity building. In doing so, ARC played a dual support role for both the fellow and the FP/RH program staff in both Darfur and Rwanda.

3. Methodology

Via its involvement with RAISE, ARC was able to establish a relationship with the Fellowship in FP program and in early January 2009 one OB/GYN MD fellow was placed in ARC’s health programs in South Darfur and Rwanda. The field placement permits the fellow to participate in on-site follow-up FP/RH training. The fellow spent four weeks in Darfur with the ARC RH team, including both international and national staff, providing technical assistance and capacity building to their RH programs, including FP and EmOC. In addition to the abovementioned activities, the fellow spent significant time with refugee beneficiaries in Rwanda, conducting qualitative research through household interviews to further investigate barriers to FP usage.

4. Data (if relevant)

N/A

5. Findings

Participation in professional networks, like RAISE, allowed ARC to 1) broaden its knowledge of and access to skilled fellows, resulting in stronger FP/RH services at the field level in Rwanda and Darfur; 2) expand its range of FP/RH opportunities to better meet staff and client needs in the field; and 3) gain increased access to FP/RH information and expertise, resulting in improved program efficiency, contributing to a larger reach and stronger impact at the services level. This is particularly highlighted by the FP Fellow Case Study, resulting in stronger technical advice and support via creative use of opportunities available through RAISE.

6. Program: State lessons learned

ARC’s involvement in professional networks, such as RAISE, has led to a broad range of opportunities, of which one was the Fellowship in FP Program. The extent to which ARC has benefitted from this network and collaboration has been substantial, including:

- Increased ability to meet technical demands from the field: Headquarters Technical Units are often constrained by a number of factors: competing priorities, limited RH technical staff/funding, and insufficient time for extended TA visits. ARC was able to better meet the demands of the field by leveraging external support through its participation in RAISE and collaboration with the Fellowship in FP Program, thus highlighting that high quality technical support to field programs is possible through the use of creative alternatives.

- Deploying innovative alternatives to optimize technical support opportunities: Professional networks provide both direct technical support and increase an organization’s access to more technical opportunities; however, the organization itself must be innovative and able to merge opportunities with field realities to optimize the opportunities that exist. ARC recognized an opportunity, successfully used and supported a proxy TA, via the FP Fellows placement, allowing for ARC to strengthen its technical support in two countries. ARC also spent considerable time liaising with the fellows group to ensure that the opportunity would be valuable for all, both field, HQ, and the fellows group, resulting in a mutually beneficial experience.

A10: 4

Reducing Fertility in Ethiopia: Results of a Radio Serial Drama

Kris Barker, Negussie Tefera

Population Media Center, South Africa; krisbarker@populationmedia.org

Background/Significance

Ethiopia has the second largest population in Africa—79 million—and, given its annual growth rate of 2.6%, its population is estimated to double in 29 years. Ethiopia’s fertility rate is among the highest in Africa, at about six children per woman.

To respond to these issues, Population Media Center (PMC) created and produced a radio serial drama, Yeken Kignit, which addressed issues of reproductive health and women’s status, including HIV/AIDS, family planning, marriage by abduction, education of daughters, and spousal communication. Yeken Kignit was broadcast over Radio Ethiopia between June 2, 2002 and November 27, 2004.

Research Hypothesis

An independent research firm conducted an evaluation of the impact of Yeken Kignit in December 2004. The research hypothesis was that exposure to the radio serial drama would lead to increases in knowledge and use of family planning methods.

Methodology

A quantitative survey, using pre-post methodology, was administered to evaluate program exposure and the project’s effect on changing 1) HIV knowledge, attitudes, and behavior, 2) contraceptive knowledge, attitudes, and practices, and 3) perceptions of gender and social norms. Using a stratified, multistage sampling design, data were collected from residents in two Amhara and Oromiya regions and the city of Addis Ababa. Sample size at baseline was 2250 households and at endline 1875.

Findings
Among married women who were listeners to Yeken Kignit, current use of any family planning method increased from 12.3% to 43.5% (a 31.2 percentage point increase). Among non-listeners, use increased from 12.3% to 31.1%, an increase of only 18.8 percentage points. Among married men who were listeners to Yeken Kignit, current use of any method increased from 18.1% to 42.4%, an increase of 24.3 percentage points. Among non-listeners, use increased by only 14.6 percentage points.

Current Use of Family Planning (Any Method)

Among listeners, ever use among married women increased from 23.9% at baseline to 79% (an increase of 55.1 percentage points). Among non-listeners, ever use increased by only 23.5 percentage points, from 23.9% to 47.4%. Among married men who are listeners to Yeken Kignit, ever use increased from 28.3% to 69.6%, an increase of 41.3 percentage points. Among non-listeners, ever use increased by only 16.1 percentage points.

Ever Use of Family Planning

In addition to the above, the evaluation research also determined the following:

• 45% of women and 47% of men identified themselves as regular listeners to the program.
• The fertility rate fell from 5.4 to 4.3 children per woman.
• Demand for contraceptives increased 157%.
• Listeners to Yeken Kignit were 5 times more likely than non-listeners to know 3 or more family planning methods.
• Spousal communication about family planning issues among currently married women climbed from 33% to 68%.

Knowledge Contribution

Changing social norms on issues as sensitive and personal as human reproduction is not easy. Human behaviors are often rooted in long traditions that may once have been adaptive, but that no longer are. There is now, however, a great body of evidence that change is possible.

PMC’s serial dramas are unique in that they are designed according to elements of communication and behavioral theories. These confirm specific values, attitudes, and behaviors that viewers can use in their own personal advancement, and for the betterment of the world.

PMC’s dramas are popular because they (1) are entertaining, (2) address issues of concern to the target audience, and (3) reflect real-life situations and lifestyles of members of the target audience. Extensive formative research is conducted to determine the key issues that will be addressed by the serial drama and to gather information about the characteristics, needs, and preferences of the target audience. This information is used to design the characters, settings, and story lines of the serial drama.

One of the advantages of using serial dramas, rather than documentaries or single-episode dramas, is that they allow time for the audience to form bonds with the characters and allow characters to evolve in their attitudes and behavior at a gradual and believable pace in response to problems that have been well illustrated in the story line. Entertainment programs forge emotional ties to audience members that influence values and behaviors more forcefully than the purely cognitive information provided in documentaries.

Research over the past 30 years has repeatedly demonstrated the effectiveness of the methodology. Since its inception in the 1970s and 1980s, the approach has been used in more than 200 health intervention programs in more than 50 countries in Latin America, Africa, and Asia, dealing mainly with reproductive health issues such as HIV/AIDS prevention, family planning, environmental health, teenage pregnancy prevention, and gender equality.

B10: Partnerships: A Powerful Force for Change

Time: Wednesday, 18 November 2009: 11:45am - 1:00pm

B10: 1

Building consumer markets for commercially viable products: The Locon F experience

Francoise Armand, Jeffrey Barnes

Abt Associates; Francoise_Armand@AbtAssoc.com

1) Background/Significance

With close to 140 million people, Nigeria is the most populous country in Africa. The African “giant” is rapidly urbanizing, creating new and large commercial markets. Yet, Nigeria is also a country with poor reproductive health indicators, including low contraceptive prevalence estimated at 12% (DHS 2003). Although the public health system has a wide reach throughout the country, use of the private health sector is significant. Nearly half (48%) of women obtained their family planning (FP) method from a private sector source, with little differentiation by household wealth status (PSP-One Wallchart, 2005). Although reproductive health subaccount data are not available for Nigeria at this time, there is broad consensus that contraceptive commodities are mostly supplied by donors. In 2008 alone, the country received nearly $9 million in donated contraceptives (Armand, no date).

Introducing commercially viable products in sub-Saharan Africa is extremely challenging as both disposable incomes and contraceptive use tend to be very low. In addition, high levels of subsidies for commodities and services further reduce market opportunity for commercial suppliers. Until recently, contraceptive manufacturers saw the region as an “institutional market”, dominated by free or subsidized products supplied through government clinics or NGOs. To introduce commercial brands of contraceptives in this context, the USAID-funded PSP-One project pursued a segmentation strategy focused on capturing the middle market, and brokering partnerships between manufacturers of low-cost contraceptives and local distributing agents. PSP-One concurrently sought to expand the field of potential suppliers for sub-Saharan Africa by researching the global generic industry, which could supply low-cost products outside institutional procurement programs.

2) Program: State intervention/activity tested

PSP One sought to increase the sustainability of the contraceptive market in Nigeria by launching a mid-price ($1.35) oral contraceptive brand, and providing time-defined donor support to build a market for the brand. This innovative approach was implemented in Nigeria as a way to increase the sustainability of the contraceptive market, which is dominated by free and subsidized products. The project consisted of launching an oral contraceptive brand that would be sold at a price between that of the socially marketed brand and the lowest-priced commercial brand. PSP-One would identify a low-cost supplier and local distributor, and provide time-defined marketing support for the new brand. The project became reality with the signing of a distribution contract between Famy Care, a generic Indian manufacturer of low-cost contraceptives, and the Society for Family Health (SFH), a local social marketing organization. The new pill (Locon F) has a lower estrogen content than contraceptive commodities provided through the public sector and the social marketing program. Thus, it is targeted at women who want a more easily tolerated pill and can afford a fully sustainable price.
3) Methodology (including location, setting, period, analysis approach)
4) Data (if relevant)
Sales data will be presented.
5) Findings and Lessons Learned

Despite substantial registration delays, Locon F was launched in January 2009 and is now the only very low-dose, affordable OC formulation available in pharmacies. The product’s retail price recovers procurement costs and provides a 40 percent return to the NGO/distributor. The project was not without challenges: Registering the new formulation for commercial sale in Nigeria took over a year, and initial sales of Locon-F have been low, hampered by competition from free public sector products and subsidized social marketing brands. Because Locon-F does not require sustained donor support, however, its mere presence on the market constitutes protection against future commodities procurement shortages and/or funding shortfalls.

The Locon F experience is instructive for building consumer markets for contraceptive products, an essential but often underestimated challenge in the transition from “donorship” to national ownership. While still early in its implementation, the LoCon F experience conveys several important lessons, namely:
1) commercial viable low cost OCS can be introduced in sub-Saharan Africa; (2) generic manufacturers can be persuaded to launch their own brands; (3) a distributor of subsidized products may also serve effectively as a distributor of commercial products, although with some “mission conflict;” and (4) developing segmented “consumer markets” for commercial products when supply is dominated by subsidized products is a long term undertaking. In this case, national ownership can be construed as building consumer markets for contraceptive products.

B10: 2

Large-Scale Partnership to improve family planning acceptance and use in Mali
Arkia Doucoure - Diallo1, Lisa Nichols1, Binta Keita2, Timothee Gandaho2, Ramata Komate - Fomba3
1USDAID Health Program for Technical Assistance Plus (ATN PLUS) ___ Mali; 2RH Division/National Directorate of Health / Ministry of Health Mali; adoucoure@atnansante.org

1. Background/Significance
Implementing an effective family planning program has become a priority for the Ministry of Health in Mali since the 2001 Mali DHS demonstrated that family planning use had stagnated in spite of previous successes and investments in the 1990’s. Since 2003 a multi-sector group comprised of members from many Ministries and civil society in Mali, led by the Ministry of Health, has been meeting regularly to plan and develop activities to improve family planning acceptance and use. This group is one of the strongest examples in the Ministry of Health of a joint planning and coordination effort which has led to concrete and successful outcomes.

2. Research: State main question/hypothesis
Program: State intervention/activity tested
Program: Partnership Model: This approach to effective family planning in Mali is an example of partnership between MOH (Family Planning coordination committee led by the Division of Reproductive Health of the MOH), bilateral donors (USAID, Canada, Netherlands, KfW, etc.), multilateral institutions (UNFPA), NGOs and USAID funded cooperating agencies. Since 2003 the partnership has planned and implemented a wide range of family planning service delivery components such as community based distribution, mass media development, and improved quality of family planning service delivery through updated training in FP methods. It also implemented operations research on the effects of the family planning campaign and a situation analysis of FP service delivery nation wide.

3. Methodology (including location, setting, period, analysis approach)
The Family Planning working group works according to the following structure:
• Routine meetings of the Family Planning Partners from the Ministry of Health, the Ministry of Social Affairs, the Ministry for the Advancement of Women, and various other partners from the public and private sector led by the Reproductive Health Division of the Ministry of Health meet on a quarterly basis (sometimes more frequently). The group can be as large as 25 or as small as 10.
• The FP partners developed a joint workplan, which brings together multiple program and project workplans to improve FP acceptance and use.
• Smaller sub groups (of less than 10) which focus on the organization of specific activities, such as a Family Planning campaign, family planning situation analysis of service delivery, effects of family planning campaign and specific communication activities are convened when needed or when the skills of certain members (i.e. communications) are required. These sub groups then report back to the larger group.

4. Data (if relevant)

5. Findings
The workplan to improve family planning acceptance and use has been successfully implemented (over 30 different activities are planned and implemented yearly) including five national Family Planning campaigns also held in the regions. CVP has increased by 15% and awareness of family planning has increased. The FP partners group has successfully focused on increasing male involvement in family planning and getting high level leadership to launch the FP campaign. Funding to FP activities was better coordinated and in this coordination the duplication of activities was avoided and a more efficient use of resources has occurred. The Government of Mali opened a line item in the national budget to contribute 10% to contraceptive security each year.

6. Research: State knowledge contribution
Program: State lessons learned
The Mali Ministry of Health will continue to promote this successful working group. Technical and financial partners in Mali use the FP partners group as a model for other technical working groups. Funds are mobilized and better coordinated for FP because of the efforts of the FP partners group.

B10: 3

Creating a Compendium of Best Practices: Contributions of the IBP Kenya Team
Marsden Solomon1, Monica Wanjuru1, Joyce Lavussa1, Bartlol Kigen2, Amanda Abbot2
1International Conference on Family Planning: Research and Best Practices

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Background

Globally, there have been several efforts to identify and document best practices in Reproductive Health/Family Planning (RH/FP) services that improve service delivery. Internationally, the IBP Consortium was set up to advance the documentation and dissemination of knowledge about best practices to improve RH outcomes.

In Kenya, a deliberate effort has been made to refocus attention on critical programmatic needs and apply identified best practices. Kenya has spearheaded a number of RH/FP initiatives that can be classified as best practices. However, these are either not documented or used. Significant gaps in documenting and sharing of best practices in Kenya has resulted in missed opportunities, duplication of efforts and costly implementation of ineffective programs.

To address this problem, in 2008 the Division of Reproductive Health (DRH) in the Ministry of Health (MOH) Kenya commissioned a process to identify and document the best practices in RH/FP that have been implemented in the country. A compendium of best practices in RH/FP is under development.

Objective: To describe the process of developing of a “Compendium of Best Practices” in Kenya.

Methodology

The first step was the establishment of a Best Practices Task force, whose mandate was to lead the process and provide technical guidance to the DRH. This task force is chaired by the DRH and comprised members drawn from the initial IBP Kenya country team.

The task force objectives included:

- To develop, produce and disseminate a compendium of the best practices in reproductive, maternal and neonatal health Kenya.
- To develop an implementation guide for program managers in public health programs.
- To orient service providers on the value of documenting and “managing change.”

The task force carried out the following activities:

- Defined what is a best practice, and promising practice;
- Led the process of identifying interventions that would be considered as a best practice;
- Developed a evaluation tool for submitted interventions; and
- Assisted the DRH to hire a consultant to identify the best practices and compile the compendium...

These activities were coordinated by the DRH, with the assistance of World Health Organization (WHO) and Family Health International (FHI), which provided secretariat services.

- The evaluation tool had the following criteria for selection of best practices to include in the compendium: replicability, sustainability, utilization of services and cost effectiveness. Cost effectiveness was determined by looking at the Cost involved to support the intervention and the resultant Effect/Benefits e.g. increase in RH/FP uptake
- The DRH sent out a call to all RH/FP implementing organizations in Kenya to submit entries for consideration as best practices.

A total of 37 submissions from various RH/FP partners including NGOs, private sector institutions and other groups were received. All practices received were entered on a standard form developed by the Task Force, borrowing heavily from one developed by Africa Population and Health Research Centre. The practices were then submitted to the evaluation tool and scored. Practices scoring more than 70% were regarded as best practices. Practices scoring less than 70% were either considered promising or disqualified.

Eight out of 37 submitted practices have been selected as best practices and – out of the remaining, 5 have been selected as promising practices. These selected eight practices have formed the inaugural Kenya compendium on RH/FP best practices. The compendium is currently being reviewed and finalized by the Task Force. The eight best practices covered topics in: Family planning, and Integration of FP/HIV Services and Safe motherhood. The compendium will be printed in June 2009 and subsequently disseminated nationally. The compendium will be available to share with participants at the Kampala Conference.

Findings/Lessons Learned

It is feasible to identify RH/FP best practices at the national level that contribute toward closing the knowledge-to-practice gap and to meeting reproductive health goals. Involvement of IBP country team members under the leadership of the DRH enabled broad ownership of the process; many partners felt confident to be part of the process and invested in the product. The evaluation tool and scoring system helped define standards for identifying best practices, and it is anticipated that this process can be replicated in other countries.

The process however, was not without challenges. There were a number of challenges experienced in the different stages of this effort, including the lengthy documentation process and a reluctance of partners to share their practices. (Other challenges and lessons learned will be described in detail in the presentation.) Nonetheless, this exercise is very important as it narrows down the key practices that can be replicated and ultimately result in improvement in quality of RH/FP services.

B10: 4

Partnering with faith-based organizations to diminish unmet need for family planning in Rwanda

Laura Hurley, Laura Hoemeke, Suzanne Mukakabanda, Gaspard Bayigane
Intrahealth International, Rwanda; lhurley@intrahealth.org

1. Background/Significance

While Rwanda has made significant strides recovering from its tumultuous past, the country has retained a high level of fertility (Total Fertility Rate of 6.1) and 42% unmet need for family planning (Demographic and Health Survey, or DHS, 2005). Rwanda also has a strong tradition of health care provision by faith-based health facilities (38% of all public health facilities nationwide are faith-based, primarily Catholic). While the high unmet need for family planning (FP) illustrates a great opportunity, most faith-based health facilities (FBHFs) do not offer modern methods of FP. To overcome this obstacle, the Twubakane Program has supported the Ministry of Health, FBHFs, districts and sectors in a unique partnership: FP secondary posts.

2. Intervention/activity tested

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The Twubakane Program, in collaboration with the FBHFs and district and sector authorities, has supported the establishment of 26 FP secondary posts in eight districts. These secondary posts are often small rooms in nearby sector administrative offices.

3. Methodology (including location, setting, period, analysis approach)

Through stakeholders’ joint planning meetings, Twubakane program staff, local district and sector health authorities and FBHF directors developed a strategy to offer FP services. Following the strategy development, FBHF directors and health district and sector authorities agreed to FP action plans. Twubakane program staff trained FBHF providers in clinical FP, and FP secondary posts were established near FBHFs to offer FP counseling and modern methods to clients. To set up the secondary posts, the administrative authorities identified a room, often in the sector offices, and Twubakane supported the purchase of supplies and equipment, as well as training and supportive supervision to the providers. The first 15 secondary posts were established at the end of 2007 in five districts: Nyaruguru (5), Nyamagabe (3), Ruhango (2), Rwamagana (1), and Kicukiro (4). Four secondary posts were established in the second quarter of 2008 in Ngoma District. Seven more were established at the end of 2008 in Muhanga (6) and Kayonza (1). In order to monitor their progress, the Twubakane Program collects data quarterly. While some secondary posts report number of new users by method to the nearby FBHF, others send reports directly to the district hospital.

4. Data

• Contraceptive prevalence rate (CPR) increased from 10% in 2005 to 27% in 2007/2008 in all 30 districts (DHS).

• Couple years of protection (CYP) increased from 270,191 in 2007 to 436,561 in 2008 nationally, illustrating a 62% increase. In the five districts where FP secondary posts were introduced at the end of 2007, CYP increased by 73% (35,209 to 60,994). CYP in Kicukiro, a district with five FBHFs and four FP secondary posts, increased from 1,358 in 2007 to 11,012 in 2008—a seven-fold increase.

• A significant portion of the number of new FP users in 2008 received care at a FP secondary post. In the five districts where FP secondary posts were introduced at the end of 2007, 19% of all new users received modern methods of FP from the secondary posts. In Kicukiro, 2,882 of the 4,763 new FP users (61%) received FP from a secondary post. In Nyaruguru, 2,246 of the 6,839 new FP users (35%) were FP secondary post clients.

5. Findings

The FP secondary posts have measurably increased access to and use of modern contraception in Rwanda. Both supervision visits and the data above have shown that the FP secondary posts are active and succeeding in decreasing unmet need for FP. While FBHFs provide counseling on natural methods of FP, most are willing to refer clients to the FP secondary post for modern methods of FP now that they are in place.

Challenges do remain in the functioning of these FP secondary posts:

• Since the secondary posts are being staffed by FBHF staff, they are usually only open for a few hours two or three times per week. This often results in long waits for the clients and sometimes confidentiality issues for those waiting in line.

• Many secondary posts, due to limited space, material, and training, do not offer long-lasting methods of FP; this is particularly true for IUDs.

• Issues remain in some districts with integrating the data from the FP secondary posts into the health management information system.

6. Lessons learned

FP secondary posts have greatly contributed to the increase in CPR and CYP in Rwanda by expanding access to modern methods of FP and addressing a portion of the unmet need for FP. Strategies to address the challenges discussed above are being implemented locally and require district and national engagement for sustainability.

C10: Innovations in Knowledge Sharing and Networking for FP: How to Make a Difference

Time: Wednesday, 18 November 2009: 11:45am - 1:00pm

C10: 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?

Tara Sullivan, Philippe LeMay, Vanessa Mitchell, Megan O’Brien

Center for Communication Programs, United States of America; plemay@jhuccp.org

Background/significance

Health information programs aim to reach target audiences with relevant, evidence-based information that will inform decision-making and improve program quality and professional practice. Using both diffusion of innovations theory and a logic model for health information programs, the Knowledge for Health (K4Health) Project and local partners implemented a needs assessment to determine health information needs, networks, technology and tools, infrastructure, and key stakeholders, globally and in multiple regions/countries of the world. Assessing the need for and measuring the impact of these types of programs continues to be a challenge, in part, because they have not been guided by theory and/or a comprehensive logic model that links health information demand to health information products and services and to the achievement of health outcomes. Also, few agencies have conducted comprehensive needs assessment activities to determine demand for health information prior to program implementation. This multi-country needs assessment is grounded in theory and provides sound research results that will be applied to improve family planning and reproductive health (FP/RH) and other health programs worldwide.

Research questions

The main questions guiding this research are as follows:

(1) What are the health information needs of key audiences?

(2) What infrastructure exists to support information and communication technologies (ICTs)?

(3) What are the most promising technologies and tools?

(4) What health information networks exist and can they extend reach and use of health information?

(5) Who are the key health information stakeholders?

(6) What are the challenges to accessing and using up-to-date health information?

Methodology
Three methodologies were used: a health information environment scan, a global online survey, and a multi-country qualitative study. The environment scan took place from March 2, 2009 to May 8, 2009, included a focus on USAID FP/RH priority countries and consisted of a search of published literature; an Internet search for grey literature, relevant projects, and health information networks; and interviews with knowledge managers at organizations that are active members of the Health Information and Publications Network (HIPNET).

The online survey was conducted from March 25, 2009 to April 24, 2009 and disseminated using targeted e-mail announcement to USAID, WHO, UNFPA, numerous Cooperating Agencies—including both headquarters and field offices. It consisted of 39 questions covering health information topic needs, resources and tools of interest and information delivery and sharing preferences. The survey yielded 808 responses: English=540, French=88, and Spanish=180. Respondents to the online survey were well educated health professionals representing over 110 countries.

The multi-country qualitative study will take place from mid-June to mid-September 2009 in Asia (India), LAC (Peru), and Africa (Ethiopia, Uganda, South Africa, Malawi). Key informant interviews will be conducted with senior level technical officers from stakeholder organizations and with members, organizers and administrators of existing health networks. Focus group discussions will be facilitated with main audience groups (program managers, information specialists/librarians, health care providers and community health workers).

Data/findings

Results from the environment scan show that health care providers and managers commonly complain about: lack of materials, inappropriate and irrelevant materials, high costs and lack of access to the Internet, limited access to meetings and medical societies, time pressures and lack of a reading culture (Kols, 2009). Respondents to the online survey reported amount of information (too much or too little), time, limited access to computer/Internet/technology, slow/inconsistent internet, cost, and lack of access to journals as barriers to accessing and using health information.

In developing countries health care managers and health service providers meet their health information needs through activities sponsored by the facility or the health care system, official materials, discussions with colleagues and textbooks (Kols, 2009). Studies show that health professionals need information that is trustworthy, up-to-date, relevant to the local context, practical, easy to digest, convenient and accessible (Kols, 2009). According to the online survey, the top ranking information resources include: research/journal articles, handbooks, fact sheets, graphs/charts, implementation guides, and reviews/syntheses. Top ranking electronic resources include: Web search engine, Online training/e-learning, Databases, CD ROM, and Online forums. Demand for FP/RH topics include: Adolescent RH, Integration FP/MCH, Community-based FP, and Integration FP/HIV. These findings varied by job function and region.

Results have the following implications for health information program practice:

- Meet demand for FP/RH and other health topics
- Seek out and work with local intermediaries to extend the reach of health information
- Package the same content in multiple formats
- Collaborate with local partners to move information to remote areas
- Use a blended approach of “old” to “new” technologies
- Address bandwidth issues
- Explore mobile devices and new voice and video technologies

Findings from the multi-country qualitative study will shed more light on these results.

Knowledge contribution

Grounded in theory, this research yields findings that will be applied to global, regional and country health information programs—making the latest research easy-to-find and easy-to-use to inform decision-making and improve performance and service delivery quality.

C10: 2

Creating knowledge pathways to improve reproductive health

Maggie Usher-Patel1, Megan O’Brien1, Katie Richey1

1WHO, Switzerland; 1K4H/IHU/CCP; usherpatel@who.int

*Background

The Implementing Best Practices Knowledge Gateway (IBP/KG) is a dynamic collaborative networking tool that supports virtual communities of practice (CoPs) around reproductive health-related topics. It offers opportunities to exchange ideas and catalyze debates on topical issues and is designed to close the knowledge-to-practice gap. This tool was developed by WHO Department of Reproductive Health and Research in collaboration with the INFO Project at the Center for Communication Programs, Johns Hopkins Bloomberg School of Public Health (CCP) and IBP partners. Our aim is to create innovative strategies to improve access to information and promote the sharing and exchange of knowledge in and among countries through virtual knowledge networks. The simple, low-bandwidth online platform and email functionality used in the IBP/Knowledge Gateway, combined with our knowledge networking methodologies and strategies, are proving to be a best practice for improving access to information and supporting virtual networking and dialogue around the world.

*Design and Evaluation Methods

The IBP/KG is based on the principle of cooperative ownership and development. WHO and IBP partners provide technical and practical expertise to support other agencies to customize, own and manage their own knowledge networks and communities of practice. Enhancements to the IBP/KG are based on user need and implemented on a cost-sharing basis. As such, it has become a corporate tool of WHO and other agencies and is the primary knowledge sharing platform for a variety of international health organizations. Many global discussion forums have taken place on the IBP/KG, 11 of which were co-sponsored with INFO. WHO and INFO have also evaluated some of the forums to find out how useful they were to participants with regard to content, moderation, relevance to their work, and related outcomes.

*Results/Outcome and Challenges/Solutions

Launched in 2004, the IBP/KG has over 13,500 members from over 6,000 different organizations in 193 countries. Members have participated in nearly 350 virtual CoPs and more than 20 online discussion forums to exchange knowledge about evidence-based practices, debate issues and share personal experiences. Because organizations and agencies can brand and own their online communities on the Knowledge Gateway, its use has grown considerably and it now reaches over 150,000 users worldwide.
Participants typically report high levels of satisfaction with IBP/KG online forums. Almost all (99%) report that forums meet the goal of generating meaningful, relevant, and timely conversation about effective practices. Over 85% of survey respondents had already used, or planned to use, resources or practices discussed in the forums in their work. Early on, a key challenge was determining how to keep leaders engaged in managing their own communities. By spending more time orienting new members to the site and training new leaders on how to effectively facilitate a community, more communities have been successfully managed by individual leaders.

*Conclusions

The IBP/KG offers a platform for public health practitioners to share their knowledge, experience, challenges and successes in specific country-based projects that can inform policy and practice dialogue at the highest levels and ultimately improve public health practice.

C10: 3

International Association of Public Health Logisticians: Laying the Foundation for a Vibrant Online Community of Practice

Hamisu Hassan, Jennifer Antilla, Sylvia Ness

John Snow, Inc. / Making Medical Injections Safer (MMIS), Nigeria; hamisuhassan@yahoo.com

1. Background/Significance

Supply Chain Management, one of the key elements to achieving Contraceptive Security (CS), ensures the availability and choice of quality contraceptives and other reproductive health supplies to customers. Although this area is acknowledged as essential for CS, strengthening the supply chain requires human capacity to select, forecast and procure products, manage data for decision making, and distribute reproductive health commodities.

A specific challenge for public health logisticians working in resource constrained settings has been the lack of venues through which they can increase their professional knowledge and skills or share lessons learned with their contemporaries. When facing professional challenges, we most frequently turn to our colleagues as sources of information and to brainstorm, stimulating innovation, and consequently creating informal communities of practice. The International Association of Public Health Logisticians (IAPHL), established by the USAID DELIVER PROJECT in 2007, deliberately attempts to foster a virtual community of practice aimed at addressing the voiced needs of public health logisticians worldwide to network and better share their local and regional experiences, thus improving each member’s contribution to the achievement of Contraceptive and Commodity Security.

2. Program:

The IAPHL’s global nature means members must primarily communicate via listserv and postings to its website. Membership, posted tools and discussions, featured supply chain professionals of the month, and periodic discussions on special topics of interest are facilitated by the project. Discussion topics have included donor collaboration, new resources on post shipment testing of condoms, how members improved their logistics knowledge, and measuring supply chain performance. The project and Association members have shared many tools including monitoring checklists to use during site visits, a contraceptive briefing on cost effectiveness and supply chain implications of implants, information about how to access the Supply Chain Manager logistics management module (Product Tracking), Distribution Resource Planning module and one project’s Daily Activity Register.

3. Methodology

The Association started in the summer of 2007; we hope it has no end date. The IAPHL website is accessed online through a sub-site of Implementing Best Practices’ (IBP) Information Gateway at http://www.ibpinitiative.org/public/default.aspx?c=ca745ec-3b4a-400f-a055-b19ed8771066 .

The project’s approach to growing the IAPHL builds on several distinct and interdependent stages, beginning with its base. In its first two years, the IAPHL has gained valuable experience laying the foundation. By promoting member participation in the online community of practice, the priority of this stage of the IAPHL, the IAPHL hopes to facilitate growth in members’ professional capacity.

Building the IAPHL into a successful online community of practice required identifying barriers to electronic participation and developing appropriate responses. Initial invitations to logisticians who had attended supply chain management trainings provided the community with a strong base of interested and invested members. To further engage members and facilitate online communication within the group, the project actively shared new resources, featured a different member as supply chain professional each month, as well as organized and moderated periodic discussions on special topics of interest. All discussions and other postings are archived on the website for reference.

In addition, the IAPHL encouraged and supported countries with 10 or more members to organize social or technical round table events to promote face-to-face interaction and supplement online involvement. As a result of these efforts, two countries have formed chapters and at least one other country is discussing the possibility of doing so.

4. Data

Since its inception, IAPHL has grown to 373 members from 62 countries. To date there have been 436 contributions from 35 different countries. The IAPHL conducted a survey of all members in January 2009 to assess member satisfaction with IAPHL activities to date, identify member needs and barriers to online participation. Twenty two members completed the survey by the deadline.

5. Findings

It is clear from the recent survey of IAPHL members that they highly value the best practices, discussions on current issues and experiences shared by other members through the Association. Ninety-five percent of respondents reported that IAPHL had moderately or greatly increased their knowledge and/or awareness of supply chain management and access to best practices. The format of a listserv works well for information exchange and members have shared their questions, information and tools with potential for replication in other program settings. This experience indicates that such communities do not flourish without active encouragement of member participation and fostering of information and resource sharing through facilitated group discussions.

6. Program: State lessons learned

Applying lessons learned about cultivating involvement and promoting online IAPHL discussions resulted in greater and more substantive participation by members as well as increased membership through word of mouth. Through building a strong foundation for the community of practice, the Association has progressed to IAPHL members posting technical questions that subsequently ignite online discussions. These discussions increasingly focus on problems and challenges members face as they work to improve CS in their countries.

C10: 4

The 10 Elements of Family Planning Success: Engaging Family Planning Professionals Worldwide to Identify Factors for Success

Ruwaida Salem¹, Catherine Richey²
1. Background/Significance

Working toward success in family planning (FP) programs requires continual effort. FP professionals can apply best practices and lessons learned around the world to design, carry out, and scale up good-quality programs. Synthesizing and sharing local program experiences can help FP professionals learn from each other and strengthen programs.

2. Program: State intervention/activity tested

The INFO Project, based at the Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs, carried out the global knowledge-sharing initiative, “Elements of Family Planning Success.” Using multimedia tools, the INFO Project engaged FP professionals around the world to identify the most important factors contributing to successful FP programs.

3. Methodology (including location, setting, period, analysis approach)

The INFO Project rolled out this multimedia initiative in three stages between November 2007 and December 2008.

- First, the INFO Project and its partners conducted an online survey on the elements of successful FP programs using the Zoomerang™ platform. Respondents weighed in on the elements most important to success in FP programs and the elements most difficult for programs to achieve. Survey results were analyzed to rank both the most important elements and the most difficult elements to achieve.
- Second, the team conducted a two-week online discussion forum on the Implementing Best Practices (IBP) Knowledge Gateway, focusing on key elements identified by survey respondents. Forum participants responded to questions posed by the moderator and shared their personal experiences.
- In the final stage, the team developed a package of resources based on the survey results, forum discussion, and a synthesis of evidence-based information. These resources include an interactive social networking Web site launched in April 2008 (http://www.fpsuccess.org), a Population Reports issue published in September 2008, and an e-learning course launched in December 2008 on the Global Health eLearning Center (http://www.globalhealthlearning.org).

4. Data (if relevant)

- Nearly 500 health care professionals from 98 countries responded to the online survey.
- Approximately 300 FP professionals from 63 countries joined the online discussion forum. Over the two weeks participants made 88 contributions.
- Nearly 350 members have registered on the “Elements of Family Planning Success” social networking Web site. According to Google™ Analytics, since its launch the site has received over 16,000 unique visitors from 182 countries, averaging over 40 visits per day.
- Anecdotal evidence demonstrates how knowledge exchanged through this initiative was used to improve individual and program performance.

5. Findings

In general, survey respondents said that the most important factors for success are also the most difficult to achieve. The top 10 most important elements are:

- Supportive Policies: Supportive policies ensure that family planning has a prominent place on the national agenda and that adequate financial resources are allocated.
- Evidence-Based Programming: Formative research provides in-depth understanding of intended clientele. Monitoring measures progress towards objectives, while evaluation measures a program’s accomplishments.
- Strong Leadership and Good Management: Strong leadership coupled with good management helps programs improve and expand services, scale up best practices, and navigate change.
- Effective Communication Strategies: To promote and sustain healthy behavior, strategic communication programs use a systematic process to develop and carry out communication activities, drawing on behavioral theory.
- Contraceptive Security: Successful programs ensure that people are able to choose, obtain, and use high-quality contraceptives whenever they want them.
- High-Performing Staff: Using a Performance Improvement approach to build cadres of high-performing staff has proved to be effective.
- Client-Centered Care: Programs should plan and implement services with clients’ needs in mind, so that they are more likely to find a suitable contraceptive method and to continue using family planning.
- Easy Access to Service: Offering family planning services through multiple channels helps clients to obtain services easily.
- Affordable Services: Targeting subsidies to low-income users while shifting users who can afford to pay to the private sector keeps services affordable for all clients.
- Appropriate Integration of Services: Integrating services can address a wider range of health needs conveniently for clients. It also can be more efficient for programs.

6. Program: State lessons learned

Conducting this program in partnership with the IBP Initiative Partners allowed the INFO Project to tap into a wide network of FP professionals around the world. This facilitated dialogue about the elements of success in FP programming. Anecdotal evidence indicates that the participatory process contributed to the credibility and use of the outcomes. The participatory process also enabled the INFO Project to identify the information needs of field programs and to respond to those needs with field-driven information products. Moving toward this type of “pull” information dissemination strategy, whereby information programs respond to the demand or pull of audience needs, helps programs to develop information products that audiences find useful and can put into practice more easily.

d10: Gender and Reproductive Rights: The Foundation of Successful FP Programmes

**Time:** Wednesday, 18 November 2009: 11:45am - 1:00pm

**D10: 1**

The Development and Testing of a Programming Model for Addressing the Role of Men in Family Planning

**Andrew Levack, Theresa Castilla**
Over the past fifteen years, EngenderHealth’s Men As Partners Program has developed and evaluated strategies that promote the constructive involvement of men in family planning. Many of these strategies have helped family planning programs increase utilization of male contraceptive methods, increase women’s use of family planning, and improve male attitudes towards gender equality. As family planning programs around the world continue to seek ways in which to constructively engage men, a model was needed to help guide the effective design of strategies to reach men.

2. Program:
EngenderHealth carried out a comprehensive review of family planning programs that have targeted men since the 1994 International Conference on Population and Development in Cairo. The review focused on evaluated interventions shown to be either promising or effective. Based on the review, a Programming Model was developed which categorized program activities into three broad categories of 1) individual/community, 2) the service delivery system, and the 3) social/political environment. In addition, a logic model was developed to explain the theoretical basis for how program activities within each category are connected to determinants of behavior and behavioral outcomes.

3. Methodology:
The Programming Model was field tested in 2009 in the countries of Ethiopia, Bangladesh and Tanzania. Each of the three settings provided an opportunity to work with a new, large-scale family planning program that was committed to increasing men’s support and use of family planning services. The three country programs were varied in their goals. In Ethiopia, the program was committed to engaging men to increase women’s access to family planning and safe abortion services. In Tanzania, the program was looking at ways to integrate messages of family planning into couple-friendly services during PMTCT visits. In Bangladesh, the focus was to increase the utilization of long-acting and permanent methods of contraception.

4. Data:
Not relevant.

5. Findings:
In each setting, the Programming Model was successfully used as a tool for developing strategies to reach men. After program staff worked with the Model, it was determined that a series of self-assessment guides were also needed in order to walk staff through a series of questions that helped them design specific activities. In each country setting, the programs were able to develop a comprehensive set of activities that worked with men at the individual/community level, the service delivery level, and within the social/political environment. This reinforces the public health theory of using an ecological model to create change. Each setting was also able to identify activities that addressed male gender norms and attitudes towards gender equality. This is encouraging, given that other preventative work with men – particularly work addressing the prevention of HIV and gender-based violence – has been found more likely to be effective when trying to positively transform male gender norms. Until now, few examples of gender transformative work have been demonstrated within family planning programs.

6. Lessons learned
The development and application of the Programming Model for work with men has been an ongoing need among EngenderHealth’s family planning programs for many years. While our organization has a history of implementing work with men, that work has often been carried out as a small vertical program by staff with specific expertise on gender issues. Meanwhile, family planning experts managing much larger national programs often missed opportunities to reach men. The Programming Model has demystified efforts to engage men, and allowed programs to carry out simple, logical, theoretically sound activities that can influence the role that men play in supporting women’s health. Each country setting created unique and culturally appropriate activities, but they shared the commonality of using an ecological approach and addressing some element of male gender norm transformation.

D10: 2
Evidence-Based Guidelines for Addressing Adolescent Contraception in the Context of Conservatism, Poverty, and Gender-Based Violence: A Peruvian Study

Maria Raguz
Pontificia Universidad Catolica del Peru, Peru; mraguz@pucp.edu.pe

Background
Peru is chosen as a worse-scenario case for adolescent contraception for many reasons: it is one of the least gender-equitable countries in the world; Latin America is the second region in the world in gender-violence and the WHO singles Peru; and Peru is a clear example of the influence of conservative forces on social policies, as a National Official report to the United Nations recognizes, curtailing sexual and reproductive rights and gender perspective. Hence, Peru has among the highest rates in the world of adolescent unwanted pregnancy, early pregnancy, and adolescent maternal mortality -strongly linked to the 100,000 estimated illegal, clandestine and, mainly, unsafe abortions that take place every year, especially in adolescent girls in rural settings, characterized by poverty and exclusion from education, health, communications and other basic services, as well as a lack of citizenship and the realization of human rights. Nevertheless, given the countries’ inequalities, when country means are used, medium-reproductive risk qualifications make invisible these harsh realities (Countdown 2015).

A patriarchal society, women are seen as vulnerable and needing protection but, also, the authority of a man, where traditional gender identities, roles and stereotypes prevail, in the family, school, training and work environment, community, health providers, and legal and judiciary system. This led to having the worse Gender Development Indexes of the world and being one of the two countries having all of the gender indicators under the world mean. Not only Peru is a patriarchal and sexist, but “Machismo” is generalized, with women being considered of less value, males using force, violence, and other forms of power to control female sexuality, reproduction, economy and lives, and evading sexual and reproductive responsibilities, as a series of studies and publications attest. Girls and boys grow in these environments. Some girls in the study defined happiness as “not being raped”. Other studies show more than 40% of women in some Peruvian cities acknowledge they have been victims of physical violence by their partners, some, continuously. These situations express themselves in the ways adolescent and young boys and girls, and also children, view sexuality, sexual rights, sexual and reproductive health, and gender inequalities and violence, all of which are inextricably linked. In our study, adolescent females are being blamed and socially sanctioned for becoming pregnant, having and induced abortion, and even for being sexually abused, with males becoming socially justified. It also shows that when adolescent sexuality is denied, with a value-system promoting abstinence until marriage, modern contraception is seen as an adult and within-marriage issue, and young girls refuse to use it for it would imply they are voluntarily having sex, when their parents consider adolescent sex unacceptable, and even forbid them from having a boyfriend. Girls also expect boys
to protect themselves, but they do not want to use condoms and feel less pleasure, and girls feel disempowered with regard to negotiating safe sex. Boys even turn to abandonment menaces and to “love proofs” (giving in), or to the use of physical violence and even rape.

Finally, Peru has among the highest within-country socioeconomic gaps in the world, and half the population is poor, leading to adolescent girls living in extremely different realities with regard to their sexual and reproductive health, depending if they live in urban, semiurban or rural settings and in the degree of poverty and marginalization. NHS data show adolescent pregnancy is more than threefold in the Amazon, and that 78% of Cuzco pregnant adolescents claim they area having unwanted pregnancies. In poor rural communities men refer women “have to be kicked as a sack of potatoes so that they do not try to equalize with the husband”, as a Population Council study highlights.

Hypothesis
Being female puts some adolescent girls in Peru at very specific high reproductive and sexual risks. Discrimination against women combines with other social discriminations, such as age, race, ethnicity and language, education, urban/rural condition, poverty and other indicators of exclusion.

Methodology
Content analysis of qualitative results from a study with 78 girls and boys, 40 adolescents, and 46 young adults living in three poor regions in Peru, is used to illustrate how gender-based violence taints adolescent sexual health and reproductive health, with a special emphasis on contraception, adolescent pregnancy, abortion, and their social consequences.

Data
Data was gathered by trained teams of researchers using a series of techniques, including interviews, focus groups and Community Self-diagnosis.

Findings
A girl living in a poor, rural setting, being Indian, not speaking fluent Spanish, and having incomplete basic schooling, is at more risk that any other, with regard to her sexual and reproductive health, especially in gender-violent contexts and conservative societies.

Lessons Learned
Evidence shows intercultural contexts, diverse social realities and economic gaps, and the transversal realities in which adolescent sexual and reproductive health develop, need to be addressed in policies and interventions that aim at effectively responding to young peoples’ needs. This entails working with both women and men and at different levels: individual, family, society, policies, ideology.

D10: 3
Constructs of power and equity, and their association with contraceptive use among African men

Doris Bartel1, Rob Stephenson1, Marcie Rubardt1
1CARE, United States of America; 2Emory University; dbartel@care.org

1. Background/Significance
Many reproductive health programs have targeted women’s unmet need for family planning, and previous research has highlighted the barriers and facilitators in the decision for women to seek family planning services and utilize a modern contraceptive method. Many previous studies have shown the decisive role of the man’s decision-making in a couple’s use of contraception. Some studies have explored the influences of men’s attitudes and decision-making on contraceptive use. Some studies have shown that men’s attitudes about gender equity can influence condom use but less is known about the link between men’s attitudes, norms and perceptions about gender and a couple’s decisions of family planning and use of contraceptives.

2. Research: State main question/hypothesis
In order to provide an understanding of the factors shaping fertility and family planning behavior within a family planning program design, CARE and Emory University conducted quantitative population-based research to explore the question: “how do men’s perceptions of personal power and gender equity influence their reports of contraceptive use in three distinct resource-poor settings in East and Central Africa.”

3. Methodology
A closed ended survey was conducted among married women and men between the ages of 18 and 45 in a stratified random sample among rural populations in Ethiopia (West Hararge and East Hararge in the Oromia district), Kenya (Siaya district) and Rwanda (Gatsibo district in the Eastern province) in a 6-week period in the first two months of 2009. Data were collected in the appropriate language in-country (Ethiopia Oromifa, Kenya Luo and Rwanda Kinyarwanda). The survey questionnaire was adapted from the Demographic and Health Survey questionnaire for use in low contraceptive prevalence countries and included sections on background demographic characteristics, fertility and family planning behaviors, attitudes to family planning, and perceptions of community norms around fertility, family planning and gender roles. The survey questionnaire also included a 26 item scale aimed at measuring attitudes towards gender roles and expectations, and relationship factors including sex, sexuality and decision-making. The questions for the scale were adapted from the Gender Equitable Men (GEM) and Sexual Relationship Power Scale (SRPS).

Informed consent was obtained for each respondent, and each interview took approximately 45 minutes to complete. Data were cleaned and entered into STATA for analysis. The focus of the analysis was on men’s attitudes towards gender roles, sex and sexuality, decision making, perceived community norms around gender and fertility, fertility desires and myths surrounding family planning methods and influences on family planning utilization. Additional analysis examined relationships between contraceptive use, son preference and approval of contraceptive use among young married couples and a range of social, behavioral, and attitudinal indicators including those related to gender, sexuality, violence and domestic roles.

4. Data
Demographic and background data of male respondents in all three countries will be presented. Similar to recent DHS data reported by women, couple contraceptive utilization was reported by male respondents as 38% in Ethiopia, 29% in Kenya, and 6% in Rwanda. The most commonly used couple contraceptives reported by men were temporary methods such as pills and injection. Ideal family size reported by men was highest in Ethiopia, where 90% of men reported ideal family size as more than 3 children, and in Kenya where 81% of men wanted a family size of more than 3 children, and lowest in Rwanda, where no men reported ideal family size of greater than 3.

5. Findings
In a multiple logistic regression analysis, men’s gender-equitable attitudes were significantly associated with current couple contraceptive use as reported by men, along with expected factors such as current employment or higher levels of education among the couple. For example, among Kenyan male respondents,
current contraceptive use was significantly associated with gender attitudes related to tolerance for domestic violence, to gender-differentiated attitudes related to household responsibilities, and to current employment. Among Ethiopian male respondents, current contraceptive use was significantly associated with gender-differentiated attitudes about sexuality (i.e. men need sex more than women do), the power dynamics in the household, and a difference in years of education between husband and wife.

6. Discussion
The findings are important for program planners who are interested in honing the gender components of reproductive health programs that are aimed at addressing unmet need for family planning. The findings from this study allow for a more nuanced exploration of gender and power attitudes among men as they relate to family planning. The findings reveal specific constructs of gender and power among men from these 3 countries, and how each of these constructs independently influences the reporting of contraceptives.

D10: 4

Promoting Reproductive Rights and Sexual and Reproductive Health of Adolescents and Youth: Lessons learned from Colombia
Lucy Wartnerberg¹, Mona Kaidbey², Ana Cristina Gonzalez³

¹Unknown; ²UNFPA, United States of America; kaidbey@unfpa.org

BACKGROUND
UNFPA and the Ministry of Health and Social Protection in Colombia, supported the design, implementation and evaluation of national multi-media strategy to 1) strengthen the capacity of individuals to exercise their reproductive rights and take responsibility for their sexual and reproductive health; 2) improve the capacity of health care institutions and providers to respond adequately to increase access and coverage of quality sexual and reproductive health services to men, women and young people; 3) Guarantee the implementation of national guidelines for increasing the demand for and utilization of services by men, women and young people. The most important part of this programme was the attention provided to the rights of young people and to sexual and reproductive health services as basic rights to be claimed, promoted and protected. Specifically, the multi-media campaign consisted of national mass media campaign, interpersonal communication programme with community level social mobilization programme, and a training and education programme for the target groups including the service providers, and a political mobilization campaign targeting policy makers at all levels.

METHODOLOGY
The impact of the programme was evaluated using a pre-post survey carried out by an independent research institute. It also included focus group discussions and indepth interviews with a selected group of young people and adults. Each of the baseline and end surveyed covered a total 1850 and 1522 young people ages 10-18 years out of a total sample of 4,657 and 3,809 respectively. The subjects were interviewed before and after the interventions. The sample was a representative sample of young people distributed over the six departments that received the full package of programme interventions. The survey questionnaire was validated by a group of experts and was pilot tested prior to final administration. This abstract addresses the impact of the programme on adolescents and youth in 4 main areas: Knowledge of their RR and sexual health; knowledge how to prevent unwanted pregnancy; practice of pap smear; acceptance of condom use and knowledge of STI prevention.

RESULTS
The impact evaluation demonstrated a statistically significant positive impact in each of the following areas: perception of human rights and reproductive rights as linked to the exercise of sexuality; increased knowledge of how to prevent unwanted pregnancy; increase in number of young women who did a pap smear; increase in acceptance of condom for HIV prevention and increased communication among couples about STI prevention. The results were analysed showing the differential results among young men and women and among different departments.

CONCLUSION
The research underscored the importance of the focus on rights as fundamental axis for communication with youth on issues related to sexual and reproductive health, it empowers them and enhances their knowledge, motivation and communication about prevention of high risk behaviour and increases their demand for youth friendly services. On the other hand, the approach increased the understanding of service providers and policy makers about the special needs of youth. The right based approach also enhanced the understanding of the gender aspects of sexual and reproductive health information, education and services. The research also confirmed the importance of multi-media strategies and well designed mass communication campaigns in reaching young people. The study also highlighted the importance of community level interpersonal communication efforts to reach the out-of school population as part of a larger effort to begin a process of cultural transformation among the youth population. Finally, the linkage between the health and the education sectors was demonstrated to be crucial to sustaining the impact of communication programmes of this nature.

E10: Health Systems Strengthening: What to Target for Sustainable, Quality FP Services

TIME: Wednesday, 18 November 2009: 11:45am - 1:00pm

E10: 1

The contribution of the Botswana Family Planning Program to the largest fertility decline in Sub-Saharan Africa
Veronica Manana Leburu¹, Shenaz El-Halabi², Lesego Mokganya³, Samuel Mills²

¹Ministry of Health, Botswana; ²World Bank; vileburu@gov.bw

1. Background/Significance
Total fertility rate (TFR) remains high in sub-Saharan Africa with over 30 countries with TFR more than 5. In contrast, Botswana has experienced the highest fertility decline in the region (during 1980-2006) with a remarkable decrease in TFR from 7.1 in 1981 to 3.2 in 2006. The Botswana national family planning program, which was adjudged as the strongest in Africa, contributed to the decrease. The contribution of other proximate and determinants of fertility are described in the paper. We will share with participants from other sub-Saharan African countries an effective family planning (FP) program that is integrated with maternal and child health (MCH) and HIV/AIDS services. We also show that age at first birth was more important than the age at marriage as a determinant of fertility.

2. Program: State intervention/activity tested
The government showed strong commitment to meeting the family planning needs of Botswana by integrating MCH/FP and sexually transmitted infection (STI) services right from the outset in 1973. Thus, when women visit health facilities for MCH services (antenatal care, postnatal care, immunizations, and STI), they are also offered FP services. In the 1990s, HIV services were integrated too. These integrated services offered daily in a vast network of primary health care
facilities in both rural and urban areas made FP services widely available in the country. This was complemented with outreach services at mobile stops and home visits to reach out to those who do not utilize the static services. Other components which strengthened the FP program were: pre-service and in-service training of services providers; condom social marketing program (a multimedia campaign); Information, Education and Communication (IEC) which focused on training of service providers and development of IEC materials; training of non-governmental organizations (NGOs) to improve outreach services to the youth and collaboration with private providers of family planning; improvement of the contraceptive logistics system; and strengthening of the monitoring and evaluation system.

In addition to the FP program, other factors that contributed to the fertility decline are: increased age at first birth, prolonged breastfeeding, increased female education, women’s participation in the labor force, and improved survival of children.

3. Methodology (including location, setting, period, analysis approach)

The main sources of data for the monitoring and evaluation of the FP program are the nationally representative Botswana Family Health Surveys (BFHS) in 1984, 1988, and 1996, and the routine Health Information System (HIS). Regarding the HIS, the health facilities send their monthly summary sheets to the District Health Team, which in turn collates health services statistics including FP and forwards them to the central Health Statistics Unit for descriptive analysis.

4. Data (if relevant)

5. Findings

Knowledge of at least one family planning method increased from 75% in 1984 to 97% in 1996. Additionally, use of modern contraceptives increased steadily among all women aged 15-49 years from 16% in 1984 to 29% in 1988 to 40% in 1996 to 42% in 2000 (the 2008 BFHS findings awaited) will give an indication of recent contraceptive prevalence rate. Moreover, use of traditional methods decreased from 7.5% in 1984 to 0.3% in 1996. The pill was the most popular contraceptive during 1984-1996 but the use of male condoms increased from 1% in 1984 to 15% in 2000. The prevalence of injectables also increased from 1.1% in 1984 to 8.1% in 2000. Data on contraceptives supplied by the central medical stores to the health facilities (1993 to 2005) and family planning attendances shows the increased use of male condom which is attributed to the effective multimedia HIV campaign for dual protection.

The proportion of married reproductive-aged women is considered one of the proximate determinants of fertility. It is expected that the higher the age at marriage, the less likely women will potentially be exposed to sex thereby leading to fewer births and lower fertility. However, in Botswana premartial childbirth is common. Indeed the proportion of married women aged 15 years and above has declined from 43% in 1971 to 18% in 2001. Considering that childbirth is not restricted to married women, the age at first birth is a better determinant of fertility in Botswana than age at marriage. The 1988 BFHS indicated that the median age at first birth was 5 years earlier than the median age at marriage. The median age at first birth was nearly 20 years in 1988. Moreover, other contributory factors are female literacy, which increased from 36% in 1981 to 78% in 2003 and females in the labor force, which is a relatively high at 74%.

6. Program: State lessons learned

Some of the lessons learned include: i) FP integration into MCH and STI including HIV/AIDS services; ii) provide outreach services to complement static services and enhance accessibility; iii) regularly supervise, collect data and give feedback; iii) create demand for FP services through behavior change communication; iv) promote and invest in female education; v) promote policies that favor female participation in labor force; v) promote prolonged breastfeeding vi) collaboration with NGOs and development partners.

E10: 2

Upazilla Health System Strengthening – A Demand Side Financing and Integrated Approach for RH services from Bangladesh

Ahmed Al Kabir

Research, Training and Management (RTM) International, Bangladesh; alkabir@rtm-international.org

Background/Significance

Bangladesh has a comprehensive network of health care infrastructure located at Upazilla (subdistrict), union and below level. Fertility, mortality and all other health indicators are worst in Sylhet region compared to national statistics. Accordingly, RTM International in collaboration with Population Council has implemented this demand based reproductive health project (DBRHP) to develop a scalable model for the low performing areas of Bangladesh. In Sylhet region, 57% of births occur at intervals less than 36 months and over 90% of births occur at home. This OR project has demonstrated how maternal and child health and family planning can be strengthened and effectively integrated into the existing health systems operational in the area. RTM International has implemented this operational research project with financial support from UNFPA and CIDA and worked in close collaboration with the Ministry of Health and Family Welfare (MOHFW) Bangladesh and used the existing staff and facilities available in the project area.

Intervention/activity tested

Key interventions of this project are: (1) Formation of community support groups (CSGs) and strengthening of union health committees, (2) identification of facilities, training and BCC needs through a participatory manner, (3) strengthening systems and capacity by training and capacity building of the health and family planning providers and facilitates, (4) CSGs and elected representatives focused community mobilization and behavior change communication (BCC) that is targeting children, youths, mothers and their families, (5) creating demand for services through the use of vouchers for poor, and (6) strengthening the facilitative supervision and monitoring of the planned activities to improve program outputs. Existing government and NGO health workers and service providers conducts static and satellite based essential service delivery (ESD) and referrals to higher level facilities.

Methodology

RTM has implemented the project activities during January 2007 to December 2008. Base line and end line data were collected and analyzed to see the progress in outputs and systems. Process indicators were also documented and used in the final analysis. Overall improvements in child health, maternal care and family planning services were documented at different levels through an improved MIS system and shared with stakeholders for further improvements. CSGs and community leaders played a key role in the review, analysis and interpretation of progress and challenges. Policy briefs were prepared and shared with the key stakeholders. Vouchers were distributed among poor and vulnerable population to ensure EOC services including ANC and PNC.

Findings

In the project area the performance of all health care services have improved between a range of 12 to 30 percent from the base line during a period of two years. The participation of CSGs and community leaders in the implementation have developed and transferred real ownership of health care facilities and it is expected that a long-term impact is created from this initiative. Integration of all health care services has improved the performance of all services including family planning, reduced missed opportunities, and improved referrals of complicated and EOC cases to higher level facilities.
Lessons learned
Demand side financing and community participation are crucial for a successful reproductive health (RH) program. Integration of services can reduce missed opportunities and can strengthen efficiency of program performance and outputs. However, to develop a sustainable system and program for primary health care, existing systems and resources should be effectively utilized and a combination of both demand and supply side approaches should be under taken through a bottom up approach. CSGs and local level planning can also help the program implementation very effectively. However, effective and supportive supervision is important side by side with reward and punishments for any successful program.

E10: 3

**Strengthening Family Planning and Reproductive Health Programs Through Better Health Systems**

*Ayman Mhosen, Barbara Seligman*

Abt Associates, United States of America; barbara_seligman@abtassoc.com

A strong health system is central to reducing inequities in family planning and reproductive health service use and outcomes.

A health system consists of all organizations, people, and actions whose primary intent is to promote, restore, or maintain health. In this presentation we follow the health systems strengthening framework of the World Health Organization, which defines six building blocks, notably: service delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership and governance. For each of the building blocks we discuss principal challenges, and proven approaches to address them. We also provide examples showing how strengthening each of the building blocks can lead to improvements in equity, access, quality, efficiency and sustainability.

We look at the experience of performance-based financing (PBF) mechanisms and credentialing in improving provider performance and efficiency, and the overall quality of FP/RH services. We examine experience in using risk protection and demand side-financing mechanisms to increase equity and access in FP/RH use, particularly among the poor. Finally, we look at the contributions of strong governance, information systems and commodity management in improving efficiency, access and the sustainability of FP/RH programs.

**F10: Addressing Youth Special Needs: Lessons Learned from Research**

**F10: 1**

**Youths As Effective Role Models in Integrated HIV and Family Planning Program in Rural Community - Lessons learnt from a Youth FP/HIV intervention in Nwaorieubi, Imo state of Nigeria**

*Cornel Ekeh, Ben Ofudje, Anthony Obilor, Blessing Obasi, Oluchi Ofurum*

Society for Family Health, Nigeria; Cornel316@yahoo.com

**BACKGROUND:**

An integrated HIV and family planning program was implemented by the Society for Family Health (SFH) in a rural community of Imo state in Nigeria. It was designed to support and strengthen Nigerian government’s health systems efforts to improve the health status of the mother and child. It also seek to create awareness on Family Planning (FP) and HIV, share information about myths and misconceptions about child spacing with the aim of clarifying, correcting and providing accurate information on FP methods and HIV.

**HYPOTHESIS**

This paper documents lessons learnt among youths in Nwaorieubi community of Imo state.

**METHODOLOGY**

Youths in this intervention community were mobilized and educated on knowledge of HIV and Family planning methods using the peer education strategy. Forty peer educators (PE) were selected and trained for a period of one year. Peer sessions were conducted by the PEs using the Peer Education Plus (PEP) and FP manuals among peers. Peer group meetings were based on FP issues and mode of delivery was through interpersonal communication (IPC). Aside peer group sessions, the intervention mix included dramas and board games.

**FINDINGS**

The intervention program effectively integrated FP and HIV/AIDS issues. At the end of the one year intervention period, participants designed and implemented programmes aimed at reducing risky sexual behaviour and improving the adoption of FP methods in the community. The project also helped in improving care and support for Persons Living with HIV/AIDS.

Program impact led to increase in basic knowledge of prevention and transmission of HIV/AIDS and unplanned pregnancies. Most importantly, it led to the formation of community based youth organizations (CBOs) for sustainability of behaviour change and behaviour maintenance in the community.

**LESSONS LEARNED**

The effective adaptation and integration of other components of community development programmes with family planning issues, is useful to make impact in smaller communities. This can be scaled up to other communities with similar characteristics. This is a key component of development in Africa, and it will go a long way in the step to achieving the millennium development goals.

**F10: 2**

**Reaching young mothers and young girls with postpartum family planning services in Haiti**

*Lucito Jeannis*, Robin Anthony Kouyate1, Véronique Dupont1

1Jhpiego, 1Academy for Educational Development, United States of America; rkouyate@jhpiego.net

**Background**

In Haiti, according to the 2006 Demographic and Health Survey approximately 50% of births among 15-19 year olds and 24% of among 20-29 years olds occur less than 24 months after the previous delivery; these pregnancies occur within the first 15 months postpartum. Another 40% and 38% of births occur between 24 and 35 months for each of these age groups respectively. Among younger Haitian women in the first year postpartum, only 18% of 15–24 year olds reported using a method of contraception, although 97% of young mothers under 25 years of age desired another birth within two years after delivery. Additionally,
among postpartum women, trends of contraceptive uptake method indicate much lower contraceptive use among 15-19 year olds, with approximately 15% using a method compared to about 25% of postpartum women older than 30 years.

Objectives: To address this identified higher unmet need for FP among 15 – 24 young mothers and girls, an intervention integrating youth friendly PPFP services into existing FP services was implemented, in conjunction with participatory community-based initiatives to increase the demand and supportive environment for family planning service and method use.

The goal was to increase young women’s (15–24 years) use of existing sexual reproductive health and family planning (SRH/FP) services and contraceptive methods.

Specific objectives were to promote: 1) the use of postpartum family planning for the healthy spacing of births among young mothers, and 2) the healthy timing of births among young girls.

Intervention design and implementation: In collaboration with the Ministry of Health, one urban and one rural and one urban site were selected for program intervention in the Department of Nipples. Formative and participatory research in these program areas indicated that several factors may influence early and closely spaced births: 1) a lack of in-depth knowledge among youth on sexual and reproductive health; 2) early initiation of sexual activity at 13–14 years of age; 3) widespread beliefs about fertility caused by FP; 4) little communication between parents/other adults and youth about SRH; 5) economic factors that influence young mothers’ and young girls’ sexual interactions; and 6) youth dissatisfaction with SRH/FP services, particularly with provider attitudes.

Informed by research results, a three-pronged approach was developed to achieve program objectives: 1) improve the quality of reproductive health and family planning services for youth by integrating PPFP and HTSP counseling tailored to adolescents into existing FP services; 2) increase the demand for SRH/FP services and methods through educational sessions with young mothers and young girls in the facility and the community; and 3) create a supportive social environment for adolescent service use through parent support groups, community awareness raising activities, and radio programs.

Results: An assessment of program outcomes is being conducted through analysis of services statistics, a youth-friendly services rapid assessment and qualitative interviews with community groups. Preliminary analyses of service statistics indicate increased trends in FP method use among 15 – 24 year old women in the rural program sites in the current first quarter by 55% – 74% as compared to one year ago. Preliminary observed trends in FP method use in the program urban site are less conclusive. A follow-up youth friendly services assessment at the two health facilities receiving youth friendly services training indicate youth perceived positive shifts in provider attitudes. Similarly, training post-test results indicated that providers gained a better understanding of 1) methods appropriate for young mothers during the postpartum period; 2) youth sexual development; 3) the importance of privacy, confidentiality and respect during family planning counseling; 4) and how to address common myths and misconceptions about contraceptives held by youth.

Lessons learned: In both urban and rural areas, the approach of integrating PPFP and HTSP counseling into existing FP services appeared to have a positive impact on provider attitudes, one of the key barriers to FP service use identified during formative research. However, the approach appears to have yielded greater impact on contraceptive use in the rural site. Additional qualitative research will be conducted to identify key factors that facilitate success using this approach, as well as challenges experienced for increasing service use and increasing demand for and creating a supportive environment for FP use in the program’s urban site.

F10: 3

Qualitative Research to Improve Counseling on Dual Protection Targeting Adolescents in Dar es Salaam, Tanzania

Teresa Hoke1; Stella Mujaya2; Sebalda Leshabari2

1Family Health International, United States of America; 2School of Nursing, Muhimbili University; thoke@fhi.org

Background/Significance

Reproductive health and HIV services targeting adolescents often provide counseling to encourage dual protection, defined as any of a range of behaviors that provide simultaneous protection from unintended pregnancy and transmission of sexually transmitted infections, including HIV. Prior studies have shown provider-client communication in adolescent health services needs improvement to heighten counseling effectiveness. A better understanding is needed of the “personal meanings” that young people attach to different risk behaviors. Evidence is needed to shape practical counseling approaches that encourage culturally feasible behavioral change and that help adolescents to translate knowledge about dual protection into actual practice.

Research questions

The study is designed to answer the following:

1. How can we heighten the clarity and salience of current dual protection counseling messages targeting youth?

2. What supports are needed by reproductive health service providers to maximize the impact of their efforts to promote dual protection behaviors among their adolescent clients?

Methodology

The research consists of two qualitative components, implemented in June 2009 in Dar es Salaam, Tanzania. Both types of interviews are conducted in Swahili and are tape recorded with the participant’s permission.

Cognitive Interviews with adolescents: The research team is conducting cognitive interviews ("thinkalouds") with 16 adolescents recruited from health facilities that serve adolescents’ reproductive health needs. A cognitive interview is a process in which the respondent is asked to “think aloud” and verbalize his/her thought processes as s/he attempts to answer a question or complete a task. The interviews are examining comprehension of and reactions to currently available dual protection counseling messages derived from World Health Organization (WHO) materials. In this study, the interviewer reads a series of 7 messages included in WHO dual protection counseling materials. After each message, the interviewer asks the following:

- Tell me, in your own words, what you think the statement is saying.
- How would you give a friend this same information?
- Which words are not clearly understood?

This approach allows investigators to uncover problems associated with message comprehension, to explore how messages are received, and to identify ways of strengthening clinic-based counseling.

In-depth interviews with health service providers: The research team is conducting 25 individual in-depth interviews with providers in family planning, STL, and VCT services targeting adolescents in Dar es Salaam. The interviews include questions examining providers’ knowledge, attitudes, and practices related to
counseling adolescents on dual protection. The interviews are also exploring health service providers’ needs—including training, materials, and complementary community-based initiatives—that could enhance their capacity to deliver effective dual protection counseling to their adolescent clients.

For the two methods above, investigators are following standard techniques for management and analysis of qualitative data. These include transcription and translation into English of interview transcripts, preparation of coding trees relevant to the study questions, and computer software assisted coding and analysis.

Findings

We will present evidence produced by cognitive interviews with adolescents regarding the effectiveness and salience of dual protection counseling messages currently promoted by WHO. Specifically, the presentation will reveal common interpretations of messages, areas of misunderstanding, relevance and acceptability of messages, perceived feasibility of recommended behaviors, and support beyond counseling required by adolescents exposed to messages.

To represent providers’ perspectives, the presentation will deliver results from the in-depth interviews with adolescent health service providers. Presented results will reveal their perspectives regarding dual protection counseling. Findings will be presented on themes including providers’ understanding of what is expected of them in counseling sexual active adolescents, how they feel about providing dual protection counseling, and how they face the challenge of promoting safer behaviors to adolescents who face a host of other behavioral influences. The presentation will also highlight providers’ views on supports that would heighten the effectiveness of the dual protection counseling they provide.

Knowledge contribution

The presentation will reveal potential opportunities for improving communication strategies and messages targeting adolescents about dual protection.

PS: Poster Session 5: Taking Knowledge to Action in FP Programming

Time: Wednesday, 18 November 2009: 1:00pm - 2:00pm

PS: 1

Feasibility Study of Using Paramedics for Providing Emergency Contraceptive Services in India

M.E Khao, Shiv Kumar, Chander Shekhar, Mary Philip Sebastian
Population Council; mekhan@popcouncil.org

Background

Situations such as unprotected sex, improper use of regular contraceptives, failure of barrier methods, and sexual violence often lead to an unwanted pregnancy. Emergency Contraceptive Pills (ECP) gives woman another chance to prevent unwanted pregnancy. Government of India introduced ECP in the National Family Planning Program in 2001 as a prescription drug. Recognizing the importance of approving ECP as Over-the-Counter (OTC) drug, thereby allowing paramedics such as Auxiliary Nurse Midwives (ANM) and Lady Health Visitor (LHV) to stock and dispense it to their clients, Indian Council of Medical Research (ICMR) in collaboration with the Population Council carried out an operations research to assess usefulness and effectiveness of using paramedics in educating and providing ECP services to potential users.

Intervention

The study used post-test only study design that compared two different delivery models. In Model 1 only medical doctors were trained and provided ECP services, representing the existing service delivery practice. In Model II both doctors and paramedics (ANM/LHV) were trained in provision of ECP services.

The study was carried out in one district each from three major states of India: Uttar Pradesh (Meerut), Rajasthan (Jaipur), and Maharashtra (Thane). From each of the selected district, six Community Health Centers’ (CHC) areas were selected at random. These CHC areas were then randomly allocated to the two delivery models and one control group. The doctors and paramedics who were part of the study were trained in ECP counseling and its provision. After training all of them were given brochures and posters for raising community awareness on ECP. A pocket flipbook was also given to each of the providers after training, for making ECP counseling easy and effective.

Findings

- Before training, knowledge of both doctors and paramedics about ECP was quite low, particularly among paramedics. Training increased their knowledge dramatically. After training, knowledge of doctors and paramedics about ECP was similar.
- Six months follow up of women who had received ECP revealed that quality of counseling about ECP—it is a backup method, if used regularly it is less effective than any modern method, it does not induce abortion—use of counseling aids during educational sessions and provision of ECP brochure to client was better among paramedics than doctors.
- At nine months post training interview, high percentage (82-100 percent) of the doctors and paramedics were able to retain correct knowledge of ECP use. However, in case of control area the corresponding percentage was significantly low both for doctors (47 percent) and paramedics (21 percent).
- The average time elapsed between unprotected sex and ECP use was significantly less under Model II than under Model I (area served by doctors only). This largely because paramecia were more easily accessible to women than doctors
- Sixty six percent women who were given ECP by doctors and 67 percent women who were given ECP by paramedics could correctly answer all the four questions on ECP use-number of pills, number of doses, interval between doses, maximum time limit before which ECP has to be taken after unprotected intercourse- 6 to 9 months after they first took ECP. Multivariate analysis revealed that retention of correct knowledge was two times higher among women who were counseled by paramedics compared to doctors.
- Bridging role of ECP in increasing use of contraceptive method was demonstrated in both the areas. Proportion of women practicing family planning after using ECP for the first time increased from 67 percent to 78 percent.

Utilization

Based on these findings and advocacy efforts, Ministry of Health and Family Welfare (MOHFW), Government of India, declare ECP as OTC drug from September 2005, thus making it possible for paramedics to provide ECP services in the National Family Planning Program. Government also allowed pharmaceutical firms, manufacturing ECP, to advertise the product in mass media including TV (in India advertisement of FP method without approval of MOH&FP is not allowed)

Policy Implications
The study demonstrated that paramedics could be easily trained in provision of ECP services. Further, quality of services provided by them is slightly better than doctors. This suggests that paramedics should be encouraged to provide ECP services. This will make ECP widely accessible to women who need it. The implications for other FP and reproductive health methods and issues to be addressed by paramedics and other non-physician medical providers will also be addressed.

P5: 2

Social Marketing: Increasing Availability of Contraceptives among Rural Populations

Shuvi Sharma, Nizamuddin Khan, Pramod Kumar Tripathi

Futures Group India, India; shsharma@futuresgroup.com

1. Background

Uttar Pradesh (UP) has the second highest total fertility rate (TFR) in India, at 3.8 (NFHS III) as compared to the national level of 2.7. TFR by area of residence indicates high differentials between urban (3.0) and rural (4.1) UP. The desired fertility rates in urban (1.8) and rural (2.5) areas indicate that if these levels are achieved, the state’s overall TFR will be close to replacement level (2.1). Data also indicate that while knowledge about modern contraceptive methods is almost universal in urban and rural areas, less than half of currently married women use family planning. The percentage of women using female sterilization is 17 percent, IUDs is one percent, oral contraceptive pills (OCPs) is two percent, and condoms is nine percent.

High unmet need is compounded by limited availability of contraceptives in hard-to-reach villages having smaller populations. Incrementally higher costs of distributing products in rural areas makes it financially unviable for organizations to expand their distribution channels to villages having populations less than 5,000, leading to limited availability of contraceptives.

2. Program intervention

The social marketing program strengthens the availability of condoms and OCPs in nearly 44,000 villages with populations of 1,000–5,000 people along with community-level activities for demand creation. These activities lead to market expansion and, thus, an increase in the rural sales of condoms and pills.

The objectives of the project over two years were to:

• Increase condom sales in rural UP from 132 million pieces to 152 million pieces;
• Increase OCP sales in rural UP from 2.69 million cycles to 2.82 million cycles; and
• Ensure that at least one retail outlet stocks OCPs and condoms in 50 percent of villages with populations between 1,000 and 5,000.

3. Methodology

The social marketing program is being implemented in 70 districts of UP since April 2007. It is designed to address issues of supply and demand creation. Each district has an outreach worker and a sales representative; the former reaching communities and providing complete information on various spacing methods through interpersonal counseling, and the latter ensuring products such as condoms and pills are available in various outlets in villages. The effort is focused on villages where family planning products do not reach through routine distribution channels and that have a sizeable proportion of the overall population. Products are placed with traditional outlets (e.g., chemist shops), non-traditional outlets (e.g., grocery and cigarette shops), and potential community-level depot holders (e.g., health volunteers and RCH workers). These distribution efforts are supplemented with taxi tours to make products available in villages closer to the road head.

Various demand-generation activities include community meetings, market town activities, retailer meetings, meetings of village heads, and meetings with community health workers/volunteers. Mass media activities, such as generic promotion of OCPs and condoms, brand-specific promotion of social marketing brands, along with unconventional media, such as bus panels, have supported field-level activities to generate demand.

Tertiary sales are measured using retail audit conducted by an independent agency reporting on overall market performance for urban and rural areas. For penetration, an independent survey is commissioned to ensure that both condoms and pills are available in at least one retail outlet in the village.

4. Data

Contact authors for available data.

5. Findings

Retail outlets in villages with population between 1,000 and 5,000 are willing to stock spacing methods such as condoms and pills if products are made available to them. The penetration study confirmed that both condoms and pills were available at least one retail outlet in nearly 58 percent villages. The number of retail outlets stocking condoms is higher than those stocking OCPs. Innovative approaches to mid-level interpersonal communication, such as market town activities, strengthen supply and demand. Interpersonal communication is essential for consistent and correct messages on product usage and managing side effects, especially for pills.

6. Lessons learned

Increasing the basket of social marketing products to include health products like sanitary napkins, oral rehydration salts, and other products leads to a dilution of efforts of the sales team to promote the more “difficult to sell” products such as condoms and pills. District-level presence is needed to support development of community-based depot holders and supply products to them on a continuous basis. Retail audit, while not totally dependable to measure tertiary sales, is the only mechanism to determine whether the market has expanded. Social marketing has resulted in an increase of 27 million pieces of condoms (more than 20%) and 0.13 million cycles of OCPs (7%) over the two-year period.

P5: 3

Local-level policy and advocacy strategies to increase access to family planning for vulnerable populations in the Dominican Republic

Jeannette del Carmen Tineo, Hannah C. Fortune-Greeley

Futures Group International; jeannette.tineo@gmail.com

(1)Background/Significance:

Unmet need for family planning (FP) poses a challenge for achieving the Millennium Development Goals (MDGs), because of the strategic link between population dynamics and broader development goals. In the Dominican Republic (DR), unmet FP need is 11% among married women of reproductive age overall, but climbs much higher among the poor (15%), certain geographical regions (18%), and other marginalized populations (such as married adolescents, 28%; DHS 2007). These populations, not coincidentally, also lag behind the rest of the country in terms of achieving the basic development markers targeted by
the MDGs. Increasing access to family planning among the most vulnerable populations is an effective and efficient way to help achieve these goals (USAID Health Policy Initiative, "Dominican Republic: Achieving the MDGs"). However, at the local level, where such interventions would be most effective, a combination of economic, political, cultural, and social barriers limit the access of vulnerable population groups to FP information and services. Key barriers include myths and prejudice, failure to enforce laws, low commitment by authorities responsible for service delivery, and insufficient program funding, among others. To increase access for vulnerable populations, it is crucial to address local barriers to implementation of FP policies and services.

In the DR, the Municipality Law #176-07 regulates processes for local policies, but it suffers from poor dissemination and low awareness levels and, therefore, is under-utilized as a policy tool. It lays out specific mechanisms for community participation such as open lobbying, participatory budgets, and strategic planning, which are intended to stimulate community involvement in local policy and budget development. The law also specifies that town councils (ayuntamientos) should designate four percent of their budgets for programming for children, youth, and gender. The activity described below seeks to increase participation and leverage the potential of this public law to promote greater access to FP services.

(2) Hypothesis or Intervention Activity Tested:
The USAID Health Policy Initiative (HPI), Task Order 1, is working with local partners to leverage the commitment of resources for family planning-specific plans and budgets for the town councils, specifically in underserved municipalities. The intervention strengthens the capacity of individual and collective policy champions in the community and promotes local investment for family planning. This is an innovative strategy, as local-level Dominican authorities tend to not invest directly in family planning and depend instead on national public health policies and budgets to carry out FP activities, which often do not reach poorer or more geographically isolated municipalities. The intervention will contribute to a broader understanding of family planning as a key axis of local development—rather than being seen as just one more competing under-funded health service. To accomplish this, the project promotes a broader vision of family planning while also expanding the community advocacy base in order to increase the pressure on and commitment by local authorities to support family planning goals in the context of broader development goals.

(3) Methodology:
HPI is piloting the intervention in three underserved municipalities in different regions of the DR, from April to September 2009. The intervention fosters an active role in local policy dialogue for historically excluded groups: people living with HIV, youth, rural women, and women with disabilities, among others. A key element of this process is the creation of local advocacy networks, and building of alliances with non-traditional allies in family planning. The National Network for Advocacy in Family Planning and Sexual and Reproductive Health is working to establish local networks in the three regions by June of 2009. Through training sessions and participatory advocacy methodologies at the three sites in July of 2009, the networks will build their capacities in policy dialogue and advocacy, and develop evidence-based advocacy materials. In August and September 2009, the networks will engage in strategies to raise awareness in and provoke action by decisionmakers, such as community mobilization, policy dialogue in planning and participatory budgets, and information-sharing trainings for media outlets.

(5) Findings:
As a pilot program, the most important findings will be the documentation of the methodology training and advocacy processes that the groups undertake, so that they will be replicable in other Dominican municipalities during the later expansion phase of the project. The training materials and step-by-step advocacy/policy dialogue plans will serve as a guide for other municipalities to work on their own local FP efforts. The networks and individual policy champions strengthened during the pilot will also serve as an in-country resource for new advocacy efforts.

(6) Knowledge Contribution or Lessons Learned
The expected outcomes of the pilot are increased local programming and budgeting for family planning, as well as stronger local capacity for advocacy among civil society. This will be multiplied during the expansion phase and ultimately contribute to increased access to family planning in marginalized communities, and the long-term health and development benefits such an improvement brings, such as reductions in maternal mortality and poverty and eventual achievement of the MDGs.

PS: 4

Standard Days Method of Family Planning: Experience with Use
Samson Babatunde Adebayo, Chinazoz Ujuju, Jennifer Anyanti
Society for Family Health, Nigeria; sadebayo@sfhnigeria.org

Background
Reproductive health addresses needs of individuals, unmet needs for contraception, involvement of men in reproductive health issues, and eliminating socio-cultural and religious barriers to improving reproductive health. Introducing a family planning method that can assist couples in using natural family planning (NFP) more effectively has become a pressing demand to ensure the provision of contraceptives. Standard Days Method (SDM) is based on the knowledge that the cycle is made up of a fertile phase preceded and followed by infertile days. Women can prevent pregnancy by avoiding unprotected intercourse during the fertile phase. A string of colour-coded beads (Cyclebeads) helps users to recognise the fertile and infertile days of their cycle. The first bead is red and indicates the first day of menstruation, while the next six beads are brown and indicate period of infertility. These are followed by 12 white fluorescent beads designating the fertile window. The white beads are followed by another 13 brown beads indicating another infertile period before the next menstruation. A black rubber band is moved from bead to bead on a daily basis.

Activity tested
The study assesses the acceptability of SDM in areas where findings discovered resistance to modern family planning (FP) method due to religious and cultural issues. In addition, the issue of how users manage the 12 white bead days (fertile period) was explored in this paper.

Methodology
The study was conducted in two states selected on religious ground: Katsina (North) and Enugu (South). In Katsina state, indigenes are predominantly Hausas and practise Islam. In Enugu state, indigenes are Ibos and belong to Catholic denomination. Three urban and 3 rural Local Government Areas (LGAs) were selected in each state. Urban and rural LGAs with higher population were selected. Focus group discussions (FGDs) and in-depth interviews (IDIs) were used to elicit information from providers and users of SDM. Overall, 12 FGDs and 12 IDIs were conducted. FGDs were conducted among men and women in both monogamous and polygamous marriages who are currently using SDM for at least 6 months while IDIs were conducted among providers trained on SDM.

Findings
Participants remarked that SDM is simple to understand, easy to use and effective in preventing pregnancy. The providers revealed that initially clients were sceptical about the method. Over time, the method has become more accepted with minimal report of failure.

Findings showed that Catholic users perceive SDM to be religiously accepted. Similarly, Islamic religion and Hausa culture were perceived to accept SDM. However, it was mentioned that SDM becomes religiously inappropriate when women refuse to have sexual relationship with their husbands because of FP. Community and religious leaders played an important role in allaying fears of people about SDM. The awareness created by the district heads of some communities and the Catholic Priests helped in enhancing and expanding access through designated providers to the community members.

In Katsina State, couples in monogamous marriage use condoms during the fertile period. Male participants who introduced SDM to their wives were more likely to abstain or use condoms during the white bead days. In polygamous marriages, the number of days for the wives to be with their husbands is divided equally among all the wives. However, wives can negotiate fertile days with co-wives for free or for a token. Most men in polygamous marriages who introduced SDM to their wives usually cooperate with their wives during the white bead days as they can move to another wife after few days.

The way the white bead days were managed in Enugu state depends on the relationship and level of communication between couples. Respondents who practise abstinence may either use persuasion, pretend to be tired, avoid sleeping in the same room or travel to prevent sexual intercourse during the white beads days. While majority of the participants preferred abstaining from sex as they were averse to using condoms being Catholic, those that could not abstain usually use condoms or practise withdrawal.

Participants emphasized the absence of side effects, durability and ease of monitoring their fertile period as their main experience with SDM. To many the method has positively affected their ways of life. They trust their partners, think before they act and consider consequences of their actions. Females perceived that SDM gives peace of mind and prevents worry about side effects from hormonal contraceptives, or risks of getting pregnant.

Lessons learnt
Most users found SDM to be widely accepted. The method was religiously and culturally accepted. Condom use or abstinence during fertile days was found to be more popular ways of managing the white bead days. Male involvement is thus a key factor in making SDM effective.

PS: 5

**Addressing the Family Planning Needs of People Living with HIV in Ghana: A Community-Facility Partnership Approach.**

Olivia Edem Aghlah1, Laura Subramanian1, Nancy Russell1, Jane Wickstrom2, Betty Farrell2, Richard Killian1, Phillip Ampofo1, Edward Bonku1

1EngenderHealth/Quality Health Partners,Ghana.; 2EngenderHealth, New York; 3Development Alternatives, Inc; oaglah@ghanaqhp.org

**Background and Significance:**

People living with HIV (PLHIV), now living longer and healthier lives, are increasingly facing choices regarding sexuality and fertility and thus need access to quality family planning (FP) and reproductive health (RH) services. In Ghana, a modern method CPR of 17% (Ghana DHS 2008) indicates strong existing barriers to contraceptive use. Stigma against sexual activity or childbearing by HIV-positive men and women creates additional barriers to contraceptive use among the 1.9% of Ghanaians living with HIV (NACP/GHS 2008). In July 2007, the ACQUIRE Project/EngenderHealth began working with Quality Health Partners and other in-country partners on the “Family Planning for Healthy Living” (FPHL) project to increase awareness and use of family planning among PLHIV by increasing knowledge of individuals about family planning, and strengthening linkages between PLHIV communities and family planning service sites.

**Intervention:**

The project was conducted in 4 regions (Greater Accra, Eastern, and Western, Ashanti) in Ghana from July 2007 to May 2008. Seventy-five members of 43 HIV support groups received a 3-day peer educator (PE) training on family planning. Following the training, peer educators were deployed to give talks at monthly HIV support groups, refer peers for services, and keep logs to track activities and referrals. PEs used simple, low-cost job aids and laminated reference handouts to facilitate provision of FP information. Nineteen family planning providers from 8 referral sites received stigma reduction training and Contraceptive Technology Updates (CTU) to support provision of “PLHIV-friendly” FP services. Sensitized providers visited support group meetings to demonstrate support of FP/RH for PLHIV and answer questions beyond peer educators’ ability. Quarterly regional meetings were held to support and obtain feedback from peer educators on their activities and inform programmatic adjustments as necessary.

**Methodology:**

Prior to project implementation, baseline questioning of 180 respondents in 34 HIV support groups was conducted to assess family planning awareness and use. In April/May 2008, an endline assessment was conducted to evaluate changes in family planning knowledge and use among PLHIV and identify lessons learned. The endline sampling frame consisted of the 37 HIV support groups and 8 referral facilities involved in the project. Data collection methods included review of program reports and peer educator monthly logs; training follow-up questionnaire to assess retention of FP knowledge by peer educators; focus group discussions in each region with peer educators (n=32) and sensitized providers (n=9) regarding project implementation; questionnaire on family planning knowledge and use among PLHIV support group members (n=235); and count of referral cards received by participating providers at referral facilities. Stories of champion peer educators, providers and support group members were also documented.

**Data/Findings:**

The endline assessment of the FP HL Project demonstrated increased interest in family planning, particularly considerations for childbearing and PMTCT, among PLHIV in Ghana. Awareness of family planning increased from 95% at baseline to 98% at endline, with increased awareness of specific methods. Ninety-two percent of respondents reported receiving FP information at support groups; almost all who received information indicated that it was useful. Most endline respondents were able to spontaneously articulate benefits of FP for PLHIV, including prevention of unwanted pregnancies and HIV/STI infection and achieving desired family size. Peer educator monthly log data indicated that 255 support group members (18% of target audience) were referred for family planning services. The referral process worked most effectively when providers attended support groups and reassured people that they would be well treated at the facility. Contraceptive prevalence in support groups remained similar from baseline (38%) to endline (34%), with expanded method mix to include long-acting methods at endline. Four percent of endline respondents reported seeking FP services during the project period. Barriers to FP uptake included desire for pregnancy, fear of side effects, cost of transport, stigma/discrimination and spousal consent.

**Lessons Learned:**

The community-facility partnership approach was effective in increasing awareness of reproductive rights and family planning options for PLHIV. With sufficient training and supervision, peer educators can play a key role in informing PLHIV of their reproductive rights and dispelling myths regarding family planning methods, dual method use and risks of MTCT. Addressing persistent stigma regarding family planning for PLHIV through further rollout of stigma reduction trainings and CTU with post-training follow-up is vital to sensitizing more providers to the reproductive rights and needs of PLHIV. Provision of pregnancy counselling and services to PLHIV who desire children will build credibility of providers and ensure safer pregnancy outcomes for PLHIV. Periodic attendance by
health providers at support group meetings serves to reinforce family planning messages, build recognition and relationships between the providers and support group members, and promote greater comfort and confidentiality with referrals. Identifying champion peer educators, providers and satisfied users to advocate for family planning will facilitate implementation and scale-up.

PS: 6

Improving Reproductive Health Medical Education in Viet Nam

Huu van Ngo1, Nguyen Thu Ha1, Ton van der Velden2, Truong Quang Vinh2, Cao Ngoc Thanh3

1Pathfinder International, Viet Nam; 2Hue College of Medicine and Pharmacy; NVhuu@pathfind.org

1. Background/Significance

Vietnam Medical University (MU) graduates are not well prepared for their work in communities due to lack of practical clinical rotations at community health centers and district hospitals, lack of skills training, and the rote learning approaches used in teaching. All MUs are attempting to solve these problems.

2. Research: State main question/hypothesis

Program: State intervention/activity tested

Pathfinder International’s Improving the Quality of Reproductive Health Medical Education in Viet Nam Project (RHME) provides technical guidance to 8 of the ten Vietnamese MUs to improve approaches to RH education. The main components of the project include standardization and updating of the RH curriculum. For example, Pathfinder updated curriculae on family planning and contraception, established RH field teaching programs which promote students’ community-oriented learning, and RH skills labs for students within the universities to sharpen their classroom learned skills before they go out to practice. We strengthened clinical teaching methodologies and built the capacity of faculty and clinical preceptors.

3. Methodology (including location, setting, period, analysis approach)

The RH ME project began in 2001 as a pilot at the Hue College of Medicine and Pharmacy (Hue MU) and has been replicated since 2006 in 7 other universities. The project was guided from the start by a working group of representatives from each university Dean Board and the directors of OB/GYN departments. This enabled the deans of the other MUs to be informed of the project achievements in Hue MU and provided an opportunity for the key decision makers to identify key project areas. They also identified successes in Hue MU that could be replicated in the other 7 MUs. A Technical Support Group of senior faculty members from Hue MU selected faculty from the other MUs to provide technical support for replication.

4. Data (if relevant)

5. Findings

The quality of RH training at Hue MU has greatly improved as a result of the project. Eighty-three RH lessons (for example, antenatal care, normal delivery care, and modern family planning methods), 30 learning guides for basic RH clinical skills (including infection prevention in RH and breast and pelvic examination) and many other updated materials (such as case scenarios for problem-based learning and, student assessment tools) have been developed and used at all MUs. A RH field teaching program was established at three community hospitals and RH skill labs and is heavily utilized at Hue MU and the same three community hospitals. Theses innovative learning methods have motivated students and sensitized them to community medicine. Medical students for the first time have the opportunity and obligation to learn the practical skills of IUD insertion, family planning counseling, and other RH skills both in skills lab and in community rotations.

All faculty members of all MUs within the project have received training in modern teaching methodologies such as participatory learning, use of role-play and case studies, clinical coaching, and feedback. Modern teaching methods such as evidence-based medicine and problem-based learning have been used in RH teaching/learning activities at four medical universities. They also have all agreed to do selected clinical procedures according to standardized checklists so that students are modeled the same approach by all faculty.

The working group of deans was involved from the start of project activities in Hue MU and this early ownership and buy-in by the MU leadership and faculty, as well as adaptation of project activities to local circumstances and need, are key to this success.

Remaining challenges include ensuring that students have sufficient practice time with clients and are effectively supervised to use the skills lab optimally, as well as better coordination of didactic training with clinical skills training to ensure students have sufficient knowledge and skills before beginning clinical practice.

6. Research: State knowledge contribution

Program: State lessons learned

A combination of intensive technical intervention and policy engagement has resulted in improvements in the quality of RH medical education at Hue MU and 7 other Vietnamese universities. Students now graduate with updated knowledge and basic skills in RH care, including family planning service provision. The innovative learning techniques, synthesizing of experiences, and dissemination mechanisms are effective and worth considering for other projects.

PS: 7

The Total Market Approach in Ukraine: Increasing Access with Public-Private Partnerships

Rachel Louise Criswell, Laurentiu Mihail Stan, Olha Shmanko

Together for Health; rachelcriswell@gmail.com

(1) Background/Significance

In Ukraine, the use of hormonal contraceptive is low as compared to Western Europe or the US. In 2007, about 5% of married women of reproductive age (MWRA) used oral contraceptives, while less than 0.5% used injection contraceptives. Implants are not registered in Ukraine, while the most modern methods of hormonal contraception, such as the vaginal ring and patch are available in the private sector only at very high prices. Conversely, almost 16% of MWRA use IUDs, indicating a provider bias. Contraceptives are sold in pharmacies on a prescription basis, and the government does not procure contraceptives for the poorest populations.

The main reasons for the low use of hormonal contraceptives are health provider misconceptions about the side effects of hormones, the persisting myths among the general public regarding the bad health effects of hormones, and the limited choice of affordable methods in pharmacies. Most of the population rely on pharmacies for purchasing contraceptives, and recent analyses of private sector sales and women’s willingness and ability to pay for contraceptives have
indicated the following: 1) most pharmacies stock only high priced pills and condoms; 2) two-thirds of women are able to pay for a hormonal method priced less than $6/month; and 3) only 25% of the contraceptive needs of the middle-and low-income population are met by manufacturers.

(2) Intervention Tested

The USAID-funded Together for Health project (TFH) addressed the problem of contraceptive availability and affordability by facilitating a public-private partnership (PPP) between the Ministry of Health (MOH) of Ukraine, representative offices of leading contraceptive manufacturers and a private research institution. The PPP employs a Total Market Approach (TMA) to meet the demand for free, low-to-medium- and high-cost contraceptives for the entire population. Such an approach is especially important in Ukraine, where there is wide socioeconomic distribution of the population.

To overcome prescription barriers, TFH has trained health professionals, especially primary health care teams (family doctors, nurses, midwives), to equip them with modern counseling techniques and updated information regarding all contraceptives available on the Ukrainian market. To support clinicians, TFH worked with key academic leaders to develop Critically Appraised Topics (CATs) that address clinicians’ concerns with regards to hormonal contraceptives. Meanwhile, private sector partners funded a series of evidence-based medical (EBM) trainings for their medical representatives and facilitated the use of CATs when discussing contraception with doctors. After training, doctors were assessed to identify changes in counseling pattern.

To improve the availability of an affordable range of contraceptives, TFH worked with manufacturers to decrease prices for three products, in accordance with willingness and ability to pay (WAP) studies and trained pharmacists on the range of contraceptive options available. After training, pharmacists agreed to carry a broadened range of contraceptives at affordable prices. Trained doctors and pharmacists received a “FP-friendly” logo to market the new services to population. After training, pharmacists were monitored to assess changes in the availability of contraceptive products.

To reach the poorest of the poor, the PPP supported the national and local governments to procure contraceptives for free distribution through TFH-trained health workers.

(3) Methodology

Project field activities began in October 2006 in two oblast (regions) of Ukraine and were successfully expanded annually, currently reaching 13 oblasts. The project will complete in September 2010.

(4) Findings

More than 3,500 health workers and 2,800 pharmacists from over 2,500 health facilities and pharmacies in 13 regions were trained.

By training health professionals, the access to FP services increased considerably, and the quality of counseling improved. September 2008 monitoring showed that the number of facilities providing services increased from 293 to 929. Trained providers increased counseling for hormonal methods (POPs, COCs, emergency contraception) by 30% on average.

After 24 months of implementation, the availability of low-and middle-priced oral hormonal contraceptives (price< USD $6) in participating pharmacies increased on average by 27%; progestin-only pills by almost 20%; emergency contraceptives by 13%; and injection contraceptives by 6%.

Central and local governments mobilized over $300,000 to conduct the first-ever governmental contraceptive procurement.

Nationally, between 2006 and 2008, the sales of oral contraceptives increased by 28%.

(5) Lessons Learned

The TMA adopted in Ukraine managed to mobilize resources from both public and private sector partners to increase availability and affordability of contraceptive methods, demonstrating that partnerships between the public and private sector partners (PSP) can bring far-reaching results by drawing on the private partners’ resources, affordable priced products and large field forces.

Success was dependent on a common vision and shared information. Donors and public sector partners usually look at the availability for this reason, identifying common activities rather than broadly soliciting funds from PSPs is key. Ukraine’s TMA has a great potential for sustainability and can be replicated in other countries in the former Soviet Union.

PS: 8

Promoting advocacy to reduce gaps: Internet-based experience

Maruan Barakat, Ana Jacinto
Pathfinder International, Mozambique; jpacca@Pathfind.org

1. Background:

Although Mozambique has only 500,000 inhabitants with internet access, this number has been increasing rapidly. Pathfinder International has promoted digital inclusion as part of its capacity building process of youth activists, service providers, and program managers as well other innovative tools to promote health education.

One recently adopted tool is long distance learning using video conferencing technology. Monthly Technical Updates for providers, program managers, and activists are conducted through the internet with different local partners, benefitting both health professionals and young people.

2. Activity Tested

Every month, different themes are presented through DimDim. Via this tool, Pathfinder promotes discussion about local needs and how to empower communities to advocate and establish networks and partnerships, putting youth activists from the North and South in contact with each other. These technical updates are highly participatory and allow for identification and inclusion of expressed health needs by community representatives, health professionals, and managers.

3. Methodology:

Using DimDim, an open source platform, video, sound, presentation slides, graphs, and a dynamic whiteboard are shared virtually among users. All of these applications are running on a GPL license without any financial cost to the organization. The use of a microphone and web-camera allow video streaming via real time over the internet. The audience can participate through microphones and chat discussions with the presenters, enhancing access to information and knowledge. The use of this technology is easily replicable at the local level.

4. Findings
Does knowledge influence attitude to condom use? Observations from a nationally representative sample of Nigerian youths

Temitope Ayode Folaramni
Obafemi Awolowo University, Nigeria; topefolaramni@yahoo.com

1. Background/Significance
A good understanding of the patterns of young people’s sexual behaviour and associated factors is needed for designing effective policies that can address their reproductive health problems. While HIV/AIDS and STIs still remain a major public health challenge in sub Saharan Africa, it is clear that both risks of HIV and unwanted pregnancy are real among young people and are the most vulnerable group of people because of their low use of preventive services. Since the single most important determinant of HIV infection among young people in sub Saharan Africa is having unprotected sex with a person who is infected, consistent condom use still remains a vital tool in HIV prevention. Similarly, unintended pregnancy is another major reproductive health problem among them as most sexually active young people do not want to have children because they are in school, too young or not married. While studies have been conducted on condom use among adults in Nigeria, research gap exists with regards to young people’s knowledge and attitude to condom use.

2. Research: State main question/hypothesis Based on the proposition that knowledge of condom can influence the attitudes and practice of consistent condom and are useful for planning service delivery and condom promotion, this study aims to examine young people’s knowledge and attitude to condom use from a unique set of data collected in 2007 from a nationally-representative survey of “never married” young people in Nigeria.

3. Methodology (including location, setting, period, analysis approach) The study population comprises a nationally representative of “never married” young people who participated in the 2007 National HIV/AIDS and reproductive Health Survey (NARHS) in Nigeria. In all, a total number of 3423 respondents participated in the survey. The participants were selected from all 36 states of Nigeria through a multi-stage probability sampling method. A structured interviewer administered questionnaire was used in conducting the study. Univariate and bivariate analysis was done using SPSS.

4. Findings: 63.4% of the respondents were male while 36.6% were female. The level education was good as over 65% of the respondents have attained secondary school education. Greater than 30 % of the respondents have had their sexual debut before age 20. Over 30% of the respondents have never heard about male condom. Level of sexual activity in the last 12 months is high especially among male. However, only 12.7% of the respondents used condom at their last sex. When asked about condom efficacy, most of the respondents agreed that that condom protect against unwanted pregnancy however about 40% of the respondent disagreed that it can protect against HIV/STIs. Overall knowledge of condom efficacy is good. Similarly, Males and females who have stronger belief in the efficacy of condoms and more positive attitudes to FP were more likely to initiate sex early.

5. Research: State knowledge contribution The special risks of HIV infection and unwanted pregnancy in sub-Saharan Africa make youths an especially vulnerable population. Hence, the need to ensure effective programmes that will reach them. Among other strategies, health education and behaviour change communication programmes targeting young people in Nigeria need to consider how the issues of myths, wrong information, and poor attitude to such simple but critical interventions such as condom use impact behaviour.

Overcoming Inertia: Translating Policies into Action in Support of Integrated Programming for Family Planning and HIV Services in Tanzania

Stella Muiyaya1, Anath Rwembembra2, Maurice Hiza3, Christine Lasway4

1Family Health International, Tanzania; 2Tanzania Ministry of Health and Social Welfare - National AIDS Control Program; 3Tanzania Ministry of Health and Social Welfare - Reproductive and Child Health Section; smuiyaya@fhi.org

1. Background/Significance
The importance of linking interventions to address unplanned pregnancies and HIV infection are well acknowledged as an essential strategy for meeting international development goals and targets, including the UN Millennium Development Goals. While this recognition is broadly reflected in both the Tanzanian National Family Planning and HIV/AIDS policy and strategic guidelines, translation in practice has been difficult to occur. There are several factors contributing to this inertia, including the inability to appreciate the many lost opportunities that would mutually benefit both programs. In essence, integration should not be seen as compromising quality of the other program but maximizing the impact of both. For example, integrating FP services into HIV prevention, treatment and care services provides an opportunity to increase access to contraception among clients of HIV services who do not want to become pregnant, or to ensure a safe and healthy pregnancy and birth for those who wish to have a child. Furthermore, integration should also be seen in the other direction where integrating HIV services into the existing FP infrastructure is an opportunity to expand HIV prevention efforts and increase use of care and treatment services. Appreciation of this bi-directional phenomenon can contribute to enhanced support to overcome inertia and move the integration agenda forward.

2. Program: State intervention/activity tested
The intervention to facilitate translation of policies into action involves a strategic and systematic promotion of bi-directional integration of FP and HIV services, involving stakeholder sensitization and advocacy, situation analysis of the policy, systems, and structures to support integration, and generating local evidence on effective models of integration in Tanzania.

3. Methodology (including location, setting, period, analysis approach)
The presentation will focus on demonstrating the extent to which integration is addressed in the Tanzania national and operational policies based on desk reviews and analysis of HIV/AIDS content in Tanzania National FP and reproductive health policies and guidelines and FP content in Tanzania National HIV/AIDS.
Policies and guidelines. The presentation will also describe the factors towards the inertia to translate these policies into actions, with a focus on programmatic and system considerations. This information is gathered from a rapid assessment using the Rapid Assessment Tool for Sexual & Reproductive Health and HIV Linkages: A Generic Guide. Furthermore, the presentation will demonstrate strategies taken to promote bi-directional linkages of FP and HIV, and how it has helped to increase level of commitment and facilitate action towards integration, as demonstrated by various programmatic measures of success.

4. Data (if relevant)
N/A

5. Findings
Information presented will show that in Tanzania, similar to other SAA countries, challenges are being realized to promote the translation of integration policies into action. Evidence produced from the desk review on the analysis of FP and HIV policies and guidelines of Tanzania will be presented. The presentation will also provide findings on the health system and service delivery; how they are structured for integration. This presentation will describe how an emphasis on bi-directional linkages in FP and HIV integration are leading both the FP and HIV/AIDS program partners to identify unrealized missed opportunities and reinforce mutual synergies to comprehensively address SRH needs. Lastly, the presentation will provide the importance of the leadership role played by a coordinating body to facilitate a systematic, coordinated and evidence-based process for FP and HIV integration. Measures of success will include the formation of a coordinating and technical advisory body, updating of national service delivery protocols for providers to include integrated services, increased number of integration efforts, and the development of a National Strategic Framework for Integration in Tanzania.

6. Program: State lessons learned
The presentation will contribute to increased knowledge on ways to strategically and systematically overcome inertia when translating integration policies into action by making a case for mutual reinforcement and benefit of both programs.

P5: 11
The use of routine monitoring and evaluation systems to assess a referral model of family planning and HIV service integration in Nigeria

Nzapfurundi Otto Chabikuli, Dorka Awi, Ogo Chukwujekwu, Usman Gwarzo, Mohammed Ibrahim, Mike Merrigan, Christoph Hamelmann

1. Background
More HIV positive women on ART treatment are resuming sexually active lives and childbearing. Access to HIV services has improved but there has been no systematic effort to cater for the family planning (FP) needs of PLWH in public hospitals in Nigeria. There is no blue print FP-HIV integration model and the evaluation of FP-HIV integration programmes seldom uses data from routine M&E systems. This paper assesses the changes in service utilisation in the Global HIV/AIDS Initiative Nigeria (GHAIN) supported public health facilities using data from routine M&E systems of FP and three HIV service settings (HCT, ART and PMTCT).

2. Program:
This is an evaluation of a model that strengthened referral links between co-located FP and HIV clinics that retained same staff and used parallel supply chain management systems. The intervention consisted of upgrading providers skills, on the job support and formalisation of referrals between FP and HIV clinics. A focal person coordinated the day-to-day integration activities in FP and HIV clinics. Each facility was supervised monthly. Clients at the HIV clinics were counselled on FP methods given a referral letter to the FP clinic when appropriate and irrespective of HIV status. At the FP clinic, clients were counselled, assessed and given contraception. Clients at FP clinics were counselled on HIV and given a referral letter to the HCT clinic for testing. The service integration model guided revisions to the national FP register and informed the selection of four integration data elements:

- Clients referred from HIV clinics accessing FP services;
- The number of FP clients referred for HCT;
- FP clients receiving HCT at the FP clinics;
- HIV positive pregnant women receiving FP counselling at ANC services.

An M&E focal person in each facility oversaw the aggregation and reporting of data. Aggregated RH-HIV integration data were then transmitted to state level. M&E officers in each state added the FP clinics to their schedule of monthly data verification visits. The verified data were computerised using the District Health Information System (DHIS) software.

3. Methodology
A retrospective survey of attendance and FP commodity uptake in 71 facilities in Nigeria between March 2007 and January 2009 analysed pre- and post-integration periods. Mean attendance at FP clinics and couple-years of protection (CYP) were compared between 6 months pre-integration and 9 months post-integration period. Data on attendance at FP clinics and CYP for the pre-and post-integration periods were exported from the DHIS into Stata 10.0 for analysis. Only 40 facilities with pre-integration data and at least six months of post-integration data were included. Generalized estimating equation methods were used to compare the mean attendance and mean CYP pre- and post-integration. The p-value from the Wald test was used to assess if the difference in means was significant. An analysis of service ratios, derived by taking the ratio of completed referrals to the total client load at the referring HIV clinic. Service ratios used the most relevant and available routine data element measuring service utilisation at the respective HIV service point. The following denominators were selected:

- The number of clients counselled tested and received result at the HCT clinic.
- The number of new HIV positive clients in the pre-ART register at the ART clinic.
- The number of first ANC visit in PMTCT clinics.

4. Data (if relevant)
N/A

5. Findings
A total of 44,589 people attended FP clinics. Monthly consultations per facility increased from a range of 1 to 261 per month pre-integration to 3 to 410 post-integration. The mean attendance at FP clinic increased significantly from 67.6 pre-integration to 87.0 post-integration (p < 0.0001). Inter-facility variation in CYP ranged from 1 to 109 pre-integration and 1 to 163 post-integration. The mean CYP increased significantly from 32.3 pre-integration to 38.2 post-integration (p = 0.009). There was an increase of 4, 34 and 42 completed referrals per 1,000 HCT, ART and PMTCT clinic users, respectively, between month 1 and month 9.
Service ratios were higher in PHC settings than in secondary or tertiary hospitals. Only 3.0% of the 23,216 non-referred clients at FP clinics were males, significantly lower than referred clients from HCT and ART clinics (23.8% and 18.3%, respectively).

6. Lessons learned

Routine health data from a strengthened government health information system in a developing country can be used successfully to evaluate a FP-HIV integration programme. A simple referral model of integration achieved significant improvements of FP attendance and contraceptives uptake. Completion of referrals might be underestimated because clients referred from HIV clinics do not always attend the FP clinic the same day and may not come with their referral letter later. More effort should focus on males who attend the health facility, particularly for HIV services. Integration at PHC level with a relatively less complex service organization is more efficient.

P5: 12

Men’s Health Kit: Increasing male involvement in reproductive health

Uttara Bharath Kumar1, Faraz Naqvi2, Reuben Mbewe3, Lynn Lederer3

1Health Communication Partnership, Zambia; 2Ministry of Health, Zambia; uttarabk@hcp.org.zm

Background/Significance

According to the 2007 Zambia Demographic and Health Survey, wanted fertility rate is 5.2 children, total fertility rate is 6.2 children and unmet need for family planning among currently married women is 26.5%.

Reproductive health programs have traditionally focused on women, ignoring men’s unique needs for reproductive health information and services. There was a need for a counseling tool targeting men that would enable them to participate in making reproductive health decisions with their partners and support their partners in these decisions.

Hypothesis of Activity/Intervention Tested

Health Communication Partnership (HCP) and the Ministry of Health developed a simple, well-illustrated Men’s Health Kit consisting of a reference manual and visual counseling aid for providers. The Men’s Health Kit integrates a broad range of men’s health issues, while maintaining a focus on sexual and reproductive health and men’s participation in family health (including family planning). It also addresses emerging issues in HIV prevention such as male circumcision and multiple and concurrent partnerships, as well as myths and harmful traditional practices. It contains a referral directory for reproductive and other health services. The Men’s Health Kit can be used by health providers in a variety of settings, including work places, when counseling men.

The Kit comprises a reference manual and a free standing A4-size flip-chart.

Methodology

Implementation Steps:

• Stakeholder meeting to develop outline
• Research, writing, layout and design
• Review by stakeholders and experts
• Pre-testing with providers and modifications
• Developing distribution strategy with stakeholders

HCP sought and remained responsive to feedback from a range of stakeholders during the development process.

Data (if relevant)

HCP partnered with Jhpiego to print 15,000 copies of the Men’s Health Kit, which will be distributed to health facilities throughout Zambia as well as at all counseling points including public, private sector clinics and peer counselors at workplaces. The Ministry of Health is leading the distribution process.

Findings

The Men’s Health Kit has received rave reviews from providers, many of whom say they have never encountered anything like it and that it is a tremendously useful and innovative tool. Josephine Miyato, a nurse counselor at the Comprehensive HIV and AIDS Management Programme (CHAMP) that runs an HIV hotline said: “Last week I counseled two men from Central province using the Men’s Health Kit and this week they came to Lusaka to be circumcised. It is really working!” Josephine said she uses the Kit all the time. She added, “The Men’s Health Kit should be provided to peer counselors at the community level so that the information is made available to everyone.” Salia Muzumara, a nurse counselor at Matero Reference Hospital, says she uses the Kit it every day. “When men see the topics covered by the Kit, it helps them to open up,” going on to add, “We have a number of tools but most are for women.”

Knowledge contribution or lessons learned

• The Men’s Health Kit is the first integrated counseling tool of its kind in Zambia and is already being adapted for use by partners in other African and Asian countries.
• There was a need for an integrated male reproductive health counseling tool.
• Although designed with men in mind, parts of the Kit can be used to counsel women and couples as well.
• MHK is set to become a standard counseling tool in Zambia. Demand for this kind of tool is clear given that drafts were being used and circulated widely.
• National task forces dealing with men’s health issues served as invaluable forums to engage stakeholders and foster partnerships to develop content and add to the print run.
• The Men’s Health Kit can be used to develop training curricula, take-home materials for clients, and other linked programs.
• The Men’s Health Kit is the first tool of its kind and will be critical in generating demand for reproductive health services by reaching men wherever they interface with the health system. It can also bring men into the health system through use in alternative settings such as workplaces and communities.
• MHK can and has been adapted in various settings to deliver harmonized messages to men and improve their health seeking behavior and involvement and support for family planning.
• Actively involving the Ministry of Health and national task forces enhances ownership, fosters partnerships and avoids duplication.
PS: 13

The myths and reality of virtual facilitation and networks

Timothy R. Allen
Management Sciences for Health, United States of America; tallen@msh.org

Background/Significance

Around the world, health professionals—doctors, nurses, public health practitioners, laboratory managers, HR managers, pharmacists, and others—are leading and managing in public and private health organizations with little or no formal management and leadership training. Management and leadership practices and skills are not often addressed in schools of medicine, or even schools of public health. Given that strong management and leadership skills are crucial to successful health program implementation, a functioning health system, service delivery, and ultimately the health of the population, this is an identified gap that must be addressed.

Program: State intervention/activity tested

In response to demand from public and private health care organizations for cost-effective, practical, and accessible leadership and management capacity building, Management Sciences for Health (MSH), with funding from the United States Agency for International Development (USAID), has developed a portfolio of Internet-based distance learning programs facilitated by organizational development specialists. These programs, in priority areas, including leadership development, strategic planning, human resources management, business planning, CSO Board development, and fostering change, strengthen the leadership and management capacity of health teams and their organizations to improve health service delivery and organizational outcomes.

MSH has also developed and supports two Internet-based multi-lingual networks of more than 2,500 health professionals each: LeaderNet and the Global Exchange Network for Reproductive Health (GEN). The membership of these networks consists of health professionals interested in strengthening management and leadership in health from more than 130 countries around the world. LeaderNet and GEN host frequent online seminars conducted in French, Spanish, and English around priority management and leadership topics. On average between 150 and 300 people participate in each seminar.

Many people are skeptical of virtual program and network approaches, as they believe that it is difficult to engage participants as actively as in face-to-face programs. However, participants stay engaged in MSH virtual programs and networks as a result of active facilitation on the part of program facilitators.

Methodology (including location, setting, period, analysis approach)

Since 2002, MSH has successfully offered 35 virtual programs, reaching more than 2,700 participants from more than 360 organizational teams in 56 countries. MSH virtual networks currently enroll more than 2,500 participants each, representing 130 countries. These programs last between 8 to 20 weeks, and the seminars are generally one to two weeks in length. They require four to six hours per week of individual commitment and do not require participants to leave their worksites in order to take part.

Virtual programs and networks are facilitated by organizational development specialists who can be located anywhere in the world. Facilitators communicate frequently with participants throughout the 8 to 20 week program or the one-week seminar via the web, e-mail, telephone, and text message. For virtual programs, facilitators provide feedback and support to participants via e-mail on the deliverables the teams develop during the program—action plans, business plans, strategic plans, etc. Teams complete the program with actionable deliverables, which will help them to meet their organizational and service-delivery objectives. For virtual seminars, facilitators engage participants in rich discussion of challenges, approaches, and proven practices, and provide participants with technical information when necessary.

At the end of each program and seminar, participants complete an evaluation survey. For virtual programs, follow-up is conducted with each team 6-months post program to determine the progress they have made implementing their action plan, business plan, or strategic plan.

Findings

Participating teams in virtual programs such as the Virtual Leadership Development Program (VLDP) have reported important progress on the implementation of their action plans. For example, a team from an organization in Belarus identified the challenge of improving the care of patients with multi-drug resistant tuberculosis (MDR TB). When program follow-up was conducted, the team reported that as a result of implementing their action plan, the number of patients receiving adequate, individualized care for MDR TB increased by 21%. Another team from El Salvador identified the challenge of securing funding for access to education and reproductive health services in 640 rural communities. When the post-program follow-up was conducted, the team reported having secured a budget of $640,000 ($1,000 per community).

In a recent survey of GEN members, 70% of respondents reported using resources, knowledge, or practices from GEN in their work.

Program: State lessons learned

MSH’s approach to virtual facilitation is key to the success of MSH’s virtual programs and networks. Facilitators assist teams to develop actionable plans to address real organizational challenges and needs and facilitate discussion and exchange about real organizational challenges facing participants. Participants complete the programs with action plans that they go on to implement successfully, and participants complete the seminars with concrete approaches they can apply in their work. As a result of these programs, participating teams and individuals make concrete changes in their organizations and service delivery.

PS: 14

Family Planning Advocacy in Ethiopia: Experiences from the Consortium of Reproductive Health Associations

Zewduit Kebede Tseemma
Consortium of Reproductive Health Associations (CORHA), Ethiopia; zewdrtkt@yahoo.com

1) Background: Ethiopia’s population size and growth rate are among the highest in sub-Saharan Africa. As reported in the Ethiopian Demographic and Health Survey (EDHS, 2005), only 15 percent of married women were using contraception and the same survey indicated about 34 percent unmet need for family planning. Family planning (FP) offers multiple benefits for individuals, families and the country at large. It is among a handful of feasible and effective interventions that can make an immediate impact on maternal mortality in a low resource setting like Ethiopia. Ethiopia has one of Africa’s highest maternal mortality (673/100,000 live births) and morbidity rates, primarily due to complications related to pregnancy and childbirth. FP programs have not been given due attention though the country has promulgated in 1993 a national population policy that recognized the place of FP in the country’s development. The implementation of the population policy that set as its target an increase of the contraceptive prevalence rate from 4% to 44% by the year 2015 has failed to meet its objectives. Lack of a comprehensive program of action has partly contributed to the failure. Over the years, the country has relied on external donors for contraceptive commodities.
2) Intervention Tested: The purpose of this manuscript is to consider whether a multi-sectoral effort can be successful in getting FP considered as major component of the development agenda in Ethiopia? This paper briefly presents the experiences of the Consortium of Reproductive Health Associations (CORHA) in this regard and in family planning advocacy in general over the last decade in the country.

3) Methodology: CORHA and its partners over the years employed various strategies to advocate for FP and related issues they identified. The strategies include, among others, 1)advocacy interventions aimed at increasing awareness and changing the attitudes of policy/decision makers including regional council members and parliamentarians, as well as religious and community leaders to draw their support towards FP/RH programs. 2) Enhancing the capacity of media personnel and experts of member and partner organizations in FP/RH advocacy through series of trainings. 3) Building coalitions, strengthening networking and coordination in FP advocacy for collective actions through formation of a national advocacy network. Regional reproductive health fairs; study tours within the country; sensitization workshops, dissemination of documentary films on family planning, etc were some of the methods employed to reach the decision makers; human right activists; and the general public.

4) Findings: CORHA has been engaged in advocacy work for more than a decade now. Advocacy initiatives so far underway have been carried out through networking and collaboration. CORHA has registered significant results. The achievements that have been realized in the field of family planning in the country are the results of collective efforts between various CORHA members and partner organizations. CORHA as an umbrella organization has a coordination and leadership role in most of the initiatives. This paper focuses on the following three achievements.

The House of People’s Representatives has been—frequently discussing issues related to population and RH. Similarly, population and Family Planning has been discussed at the council level particularly in the major regions where majority of the population resides. There was a time where the house passed a resolution that the government should consider the issue of population and development first in its agenda until there is improvement in this regard.

The country’s strategic document designed to eliminate—poverty (PASDEP) has recognized population issues as a critical factor in realizing development goals, and subsequently it has included a set of targets as well as indicators in facilitating the change process. The interaction of poverty and population pressures with the productive resource base has been considered as one of the three critical challenges as the country is struggling to end poverty. Similarly, the MDGs network assessment report recognized the adverse effect of population pressures in achieving the MDGs by the year 2015 (MDGFD, 2005). The recognition accorded to the issue is a significant step that encourages in mainstreaming population dynamics in sectoral planning documents.

Allocation of budget by the Federal and Regional—Governments for the purchase of contraceptives The family planning program has been widely accepted in the major regions as a result of which CPR has dramatically increased. Regions have now begun allocating budget for contraceptives from their own treasury. This has been also done at the federal level. This is a very encouraging progress that will contribute to sustainability of FP programs in the country.

5) Lessons learnt: Collaboration and partnership was key in almost all the strategies and the methods employed. Among the collaborative efforts was the national advocacy network which is led by CORHA and has members drawn from about 16 organizations working on specific advocacy areas. However, the collaborative effort was not without any challenges. First, establishing trust and confidence among the network members have taken more time than anticipated. Second, different organization came with their agenda of interest and at times it was difficult to reach consensus on common ground; and finally, there was little experience in networking among other things.

PS: 15

Long Acting and Permanent Family Planning Skills Training in the Pre-service Education of Midlevel Health Workers in Ethiopia

Zewdu T Kebede Tessema

Consortium of Reproductive Health Associations (CORHA), Ethiopia; zewdtkirt@yahoo.com

1) INTRODUCTION: With a population of over 77 million, a total fertility rate (TFR) of 5.4 children per woman, fast population growth (2.6%), and with 65% of its population below age 25, Ethiopia faces a huge challenge to address the increasing contraceptive demand. Only 15% of women were using contraceptives at the time of the last Demographic and Health Survey (DHS, 2005), though about 49% of woman reported that they wanted to limit birth or space for at least two years. This shows an unmet need of 34%. There is also a huge discrepancy between the proportion of women who wish to stop childbearing and the proportion who are using long acting and permanent family planning methods (LAPMs). About 45% of married women want to stop childbearing but only 0.4% of women were using LAPMs. A widespread implementation of LAPMs requires a significant number of trained providers, and strengthening the pre-service education of mid-level health workers may be a cost effective and sustainable strategy for increasing LAPM service delivery. Studies in Ghana, Kenya and Zimbabwe showed that strengthening the pre-service education on FP/LAMP for mid-level health workers is strongly associated with improved FP/LAMP service provision and uptake of the services.

2) HYPOTHESIS or INTERVENTION/ACTIVITY TESTED: This study was conducted to answer the research question: why are mid-level health workers in Ethiopia not currently providing LAPMs? The study, therefore, looked into the policy and programmatic barriers to institutionalization of the LAPM skills training in the pre-service education of mid-level health workers (MLHWs) in the country.

3) METHODS: This study was conducted between August and October 2008, in five regions in Ethiopia (Tigray, SNPPR, Amhara and Oromiya regions) and Addis Ababa City Administration. Jimma, Addis Ababa, Gondar and Hawassa Universities, as well as Mekelle regional MLHWs training college and Africa Health College, were included in the study. The assessment used both qualitative and quantitative study designs. The qualitative data was collected using document review, in-depth interview, focus group discussion (FGD) and course syllabus LAPM-related content mapping. Twenty-one instructors who offer FP related courses for MLHW students in these higher learning institutions, 31 FP service providers in the clinics where the students have clinical attachments, and 24 purposefully selected FP program experts/managers working at regional and national level participated in the in-depth interviews. FGDs were conducted with 132 randomly selected graduating students in nursing, midwifery, health officer programs. One FGD was organized in each of the 14 schools in the four universities and two colleges. A total of seventeen public health experts participated in both qualitative and quantitative data collection. A total of 528 graduating students from these institutions were included in the quantitative survey that used self administered questionnaire.

4) RESULTS/FINDINGS: Findings from the in-depth interviews and review of national policy documents revealed existence of an enabling policy environment, supportive of institutionalization of LAPM skills training in the pre-service education of MLHWs. It was found, however, that there is lack of an organized effort to materialize the policy directive. MLUAPM graduates lack the required knowledge and skills to provide LAPMs, because the skill training on these methods is not well integrated in the course syllabi. The MLHWs pre-service curriculum lack essential LAPM knowledge and skill competencies. Most knowledge but skill competencies on LAPMs exist in the courses offered to midwifery students. Most LAPM-related knowledge and skill competencies were missing in the courses syllabi of health officer and nursing curriculum.

The LAPM-related skill practice opportunities are limited. There is very weak human and material resource for LAPM skills training in the training institutions. Majority (72-86%) of the 528 graduating students surveyed rated the pre-service LAPM-related theoretical and practical skills education as low. Students’
knowledge was measured using 59 LAPM-related test items. 92% of graduating students scored below passing mark (<60%) for the 59 LAPM-related knowledge test items. Most (67-81%) graduating students don’t feel prepared to provide LAPM service.

5) DISCUSSION/KNOWLEDGE CONTRIBUTION: The study has showed that there is a favorable policy environment supporting institutionalization of LAPM skills training in the pre-service education of MLHWs. The study revealed that this strategy has not been fully implemented as there are programmatic barriers for effective pre-service LAPM skill training. The MLHWs are not able to provide LAPM service upon graduation as they lack the required skills. Though midwifery students have a better theoretical knowledge than others, all categories of the MLHWs lack needed skills. Studies elsewhere have shown that a pre-service skills training for mid-level health workers is strongly associated with improved FP/LAPM service provision and uptake of the services. Relatively there are higher numbers of MLHWs (as compared to doctors) who reach every district in Ethiopia and therefore improving the pre-service LAPM’s skill training is key in achieving the set objectives in relation to family planning program.

PS: 16
A Foundation’s Role in Contraceptive Security: Highlighting the International Contraceptive Access (ICA) Foundation
Katherine Williams¹, John Townsend⁴, Klaus Britl²
¹Population Council, United States of America; ²Bayer Schering Pharma AG; kwilliams@popcouncil.org

Background/Significance
The International Contraceptive Access (ICA) Foundation, a collaboration of Population Council and Bayer Schering Pharma (BSP), donates levonorgestrel intrauterine systems (LNG-IUS) to governments and non-profit organizations in developing countries, to be incorporated in the local method-mix and distributed to women in resource-poor communities. The Foundation was founded with the intentions of increasing the use of IUS among women who would benefit from this type of contraception, particularly those with few financial resources who are unable to afford long-term contraception.

Intervention/Activity Tested
The ICA Foundation contributes to contraceptive security by expanding the supply, affordability and availability of a highly effective yet underutilized method, as well as furnishing a second-level market to the Copper-T 380 IUD, for women adverse to the side effects of the Cu-T or interested in hormonal method and/or additional medical benefits of the LNG-IUS. Country governments and non-profit organizations request for donations through a project proposal, providing information about the project’s intentions and procedures, as well as explanations of the quantity requested, the selected distribution network as well as existing and planned monitoring mechanisms.

Methodology
ICA Foundation and donation recipients maintain quantitative reports of donations, product insertions and other relevant information on recipient organizations. Detailed insight into specific country projects and distribution centers is provided through case studies and qualitative reviews. The case studies include reviews of distribution and insertion documentation, as well as interviews with donation recipients, LNG-IUS providers and family planning clients. Inquiries are made about the number of insertions, the process and challenges of product distribution and procurement, costs of product and services, role of LNG-IUS in existing method-mix, and client perceptions and satisfaction among other topics. As of May 2009, one case study has been completed, providing overview of LNG-IUS distribution in Ecuador. Two additional case studies are ongoing in Brazil and in Ghana, and results will be complete for inclusion in November’s presentation.

Findings
Since its inception, ICA Foundation has donated LNG-IUS to nine countries and is currently working with organizations in an additional five countries to create further distribution networks and provide product donations. Results from the Ecuador case study demonstrate that nearly 8,000 LNG-IUS have been donated and LNG-IUS is currently offered in 49 clinics operated by two local NGOs, APROFE and CEMOPLAF, throughout the country. Further review of the quantitative and qualitative reporting from Ecuador, as well as results from the Brazil and Ghana case study, will highlight projects that have been particularly successful at delivering LNG-IUS, challenges faced within distribution systems, as well as lessons learned and next steps for the ICA Foundation.

Knowledge Contribution and Lessons Learned
The ICA Foundation offers public systems and not-for-profit organizations an affordable and effective long-term family planning method to incorporate into their individual distribution system as they see appropriate and most efficient. A foundation’s contribution to contraceptive security, in this light, is to contribute to the reliable availability of highly effective methods, as well as enhance the market base, particularly of interest to local private systems working to increase demand and sustain contraceptive markets.

PS: 17
Translating Research to Practice: Community Based Distribution (CBD) of Depo Provera (DMPA) in Kenya
Alice Auma Olavo
Family Health International, Kenya; aoalavo@fhi.org

Background
The public sector family planning program in Kenya is characterized by: a stagnant CPR of ~39%, with 25% of women reporting unmet need, a heavy reliance on DMPA, and first year DMPA discontinuation rates of over 30%. In this context, ways to make FP use more convenient while maintaining quality are vital if any progress is to be made in increasing CPR.

Intervention
Kenya’s CBD of DMPA project supports the Ministry of Public Health and Sanitation (MOPH&S) in its efforts to increase access to contraceptive services through community level distribution of DMPA. Officials from the MOPH&S have actively participated in a series of advocacy activities, the review and adaptation of training materials and job aids, and ultimately the decision to implement a pilot program of CHW provision of DMPA in one district.

Methodology
The process of using research evidence of the effectiveness of CBD of DMPA initiative has been a long road with an initial focus on advocacy at the national level (Division of Reproductive Health) in 2007. Having gained buy-in and support, more advocacy was focused at the provincial and district level. Further, other key stakeholders including various professional medical associations were also targeted for sensitization and to seek their support of the project. Materials citing evidence of the benefits and success of CBD of DMPA in other regions were developed to aid in Kenya’s advocacy efforts. Despite initial resistance to the idea, stakeholders gradually agreed to support the initiative. This decision was aided by an educational trip to Uganda in which representatives of Kenya’s
professional associations witnessed the actual provision of DMPA by CBD agents and were convinced about the feasibility of the initiative. MOPH&S has shown support for the initiative through the formation of a project advisory committee which oversees related activities. To date, a site and selected CBD agents have been identified for the launch of the pilot project.

Lessons Learned

The process of introducing CBD of DMPA in Kenya has been quite lengthy. This underscores the fact that MOPH&S leadership and influence is critical for acceptability of potentially controversial initiatives (i.e. the provision of injectables by non medical staff). Notably, MOPH&S endorsement of such a sensitive venture and the fact that it has structures in place for successful implementation makes it easier to engage other stakeholders to provide support. Such structures include existing CBD linkages with MOPH&S health facilities including a functional supervision system.

Innovative practices which are considered "new" take time to introduce and this has implications on meeting donor timelines. Additionally, when a project is jointly undertaken, implementers must synchronize work plans for effective and efficient provision of services. Another factor that contributes to acceptance and buy-in of "new" innovations is contextualizing evidence. In Kenya, stakeholders expressed willingness to support the initiative once additional evidence on how it works in-country had been gathered.

The role played by MOPH&S especially in leadership enables such an initiative to be efficiently and effectively scaled up following positive feedback from the pilot project

PS: 18

“Learning Our Way Out”

Eshetu Yimer Yisuf
Ethiopian Rural Self Help Association, Ethiopia; eshetuyimer@yahoo.com

1. Background

Ethiopian Rural Self Help Association (ERSHA) is a national NGO legally registered under the Ministry of Justice of the Federal Government in 1997 and became operational since January 1998. During the last ten years, the organization has been implementing three Strategic Plan Periods in three regional states of the country with the major objectives of improving household food and income security, building grassroots’ capacity, promoting social equality and enhancing communities’ access to social services as basic rights.

An integrated family planning project namely “Learning Our Way Out” (LOWO) project has been implemented in one of ERSHA’S program area in three kebeles (the lowest administrative structure in Ethiopia) of the Kutcha District with the technical and financial support of IIRR. The selected kebeles are food insecure, because of recurrent drought, high incidence of diseases (both animal and human), low agricultural productivity and high population pressure in the highlands and in the villages along road sides. The settlement pattern of the community has pressed the people to hold fragmented land which is insufficient for the family. Therefore, the LOWO project has been started to assist the people to realize their situations and the root causes of the problem and come up with their own solutions.

The objectives of the Project were :  
•To increase demand for family planning services.
•Develop Standardized methods for training community facilitators in techniques that promote discussions on relationships between family size & diminished social & economic well being.
•Developing a community strategy to ensure that resources are available to respond to local demand for Family Planning services.
•Imparting skills to the project facilitators that will enable them to use the participatory method to address other community needs.
•Evaluating the success of LOWO approach using both qualitative & quantitative measures.

2. Activities Tested

•Community based saving and credit associations established
•30 community facilitators recruited & trained on basic facilitation techniques & reproductive health issues for 5 days.
•Familiarization workshop conducted for district government line departments & influential community members on the objective, strategy & impacts of the LOWO project.
•Base line survey was conducted jointly with Kutcha Integrated Rural Development Project and IIRR Awassa field office staff.
•Group dialogue sessions were conducted on topics such as HIV/AIDS transmission and prevention methods, the use of contraceptives and the impact of large family size.
•Weekly supervisory visits have been made by the LOWO Supervisor by assisting the community facilitators technically as well as seeking solutions with Community facilitators when they face challenges during conducting dialogue sessions.
•Regular Community facilitators monthly meetings conducted mainly focused on refreshing of facilitation techniques & discussion on technical reproductive health issues.
•Referral linkage with government clinics established for family planning services
•Community based contraceptive depot established.

3. Methodologies/ Strategies

•Dialogue sessions & discussions
•Distribution of IEC/BCC materials
•Capacity building of Community facilitators
•Technical training & experience sharing visit
•Monthly meetings
•Research & Documentation
4. Findings / Major Achievements

- During the project life, the interest of community members to community dialogues has been increased significantly and used as a forum to address other socio economic problems. Community members realized that population pressure has aggravated the socio economic problem of the area.
- After the start of the dialogue sessions, the number of community members that used contraceptives has increased drastically.

5. Lessons Learnt

Developing & adopting different types of picture codes and recruiting and deploying facilitators from the community has a significant contribution for the successes of the project. Refresher training for community facilitators on basic skills of facilitation & reproductive health issues enables them to manage dialogue sessions effectively. Community dialogue sessions can help to win the will of the community.

PS: 19

Knowledge, attitudes and practices of primary health care workers regarding Emergency contraception(EC) in Bukonzo county, Kasese district, Uganda.

Asa Ahimbisibwe

Kagando Hospital Kasese, Uganda; asahimbi@yahoo.co.uk

Background: Uganda is one of the low resource countries with poor maternal health indicators and the poor knowledge and low use of EC could be one of the contributors. Maternal mortality is still high (43/100,000 live births). TFR is 7.1, the CPR is at 24%, adolescent pregnancy rates of 31% and unmet need for FP of 41% (UDHS 2007). And unintended pregnancy rate of 40% (UDHS 2003).

Lack of knowledge about EC in the vulnerable groups, may be contributing to the high levels of unwanted, unplanned and unintended pregnancies that end into induced abortion. Abortion and its complications contribute 15-30% of the total MMR in Uganda (UDHS 2007, Mboonye et al 2007) and 13% of overall maternal mortality world wide (WHO/UNICEF 1999).

The continued low use of EC among the communities, persistently high levels of unwanted pregnancies that result into induced unsafe abortions and other associated complications, could be as a result of lack of accurate knowledge, poor attitudes, and practices of EC among the primary HCWs.

Primary health care workers (PHCWs) play an important role in improving maternal reproductive health. They can influence positively the use of Emergency contraception (EC) through proper counseling, prescribing, dispensing and advocacy. PHCWs have in some instances been blamed for unfavorable attitudes and lack of accurate information regarding use of EC.

Specific Objectives

1. To assess the level of knowledge of primary HCWs in Bukonzo county regarding emergency contraception
2. To describe the attitudes of the primary HCWs towards use of EC in Bukonzo county, Kasese Uganda
3. To describe the EC practices among the Primary HCWs in Bukonzo county, Kasese Uganda

Methods: This was a cross sectional study. A total of 246 PHCWs in Bukonzo county, Kasese district filled a self administered questionnaire and four key informants were interviewed. The computer program excel was used for data entry, and the data were exported to SPSS version 10 for analysis. Consistency and range checks were made and errors corrected in the Excel before exporting to SPSS version 10.

Analysis

Quantitative Data. The main outcome variables were knowledge, attitudes and practices regarding EC. The key independent variables included socio-demographic characteristics. Analysis involved descriptive statistics, such as frequency distribution tables and inferential analysis like cross tabulations that were used to explore possible relationships between the Knowledge of EC and other variables such as ever heard of EC and ever prescribed it.

Qualitative Data. The key informants were interviewed and asked a few questions regarding EC in Bukonzo County. They were interviewed individually, and their responses were written down and specific responses captured relating to knowledge, attitude and practices of EC.

Results: Two hundred and forty six PHCWs participated in this study. One hundred and fifty (61.0%) were females. Midwives/nurses contributed the majority of the respondents 150 (61%). Majority (77.6%) of the participants had heard about EC, however only 4.6% of all the PHCWs would be able to correctly administer EC. The attitudes of the PHCWs towards EC was generally positive with 80.1% and 59.8% of them suggesting that EC should be part of routine family planning and school reproductive health packages respectively. Fifty five female participants (36.7%) had ever used EC. Only 22(8.9%) of the PHCWs had ever prescribed EC in their practice although none of these knew the correct dosage of the modalities used as EC.

Conclusions: Most of the PHCWs were aware of EC, but they lacked important knowledge on its use and the available methods. The attitudes towards EC were generally positive but the practices were low.

Recommendation: There is a need for urgent sensitization of the PHCWs in Bukonzo county and other rural settings in Uganda about EC. This will equip them with accurate knowledge about EC and empower them to advocate for, counsel clients about and increase the EC uptake in the rural communities.

PS: 20

What are donors doing to ensure the adoption of evidence based family planning practices?

Nandita Thatte1, Julie Solo2, Mihira Karra2, Sarah Harbison2, Emma Ottolenghi2, Jason Smith2

1USAID, United States of America; 2Independent Consultant; 3Family Health International; nthatte@usaid.gov

Background/Significance

The USAID Office of Population and Reproductive Health (OPRH) supports many research organizations to develop new tools and methodologies that improve service delivery and access to healthcare and family planning worldwide. During the last 5-10 years the OPRH, through its research cooperating agencies (CAs), has placed an emphasis on ensuring that these evidence based research results are disseminated and used in the field. Recently the OPRH decided to evaluate efforts on research utilization (RU). In August 2008, through the Research, Technology, and Utilization (RTU) division, the USAID/OPRH initiated a 4 country assessment of research utilization (RU) activities by CA partner Family Health International (FHI).

Hypothesis or Intervention/Activity Tested
The purpose of the assessment was to identify the impact of research utilization efforts on family planning outcomes and to determine whether housing research utilization efforts in a research agreement was an appropriate model for ensuring the use of evidence based practices in programs and country settings.

Methodology
A team of four consultants traveled to Kenya, Uganda, Rwanda and Madagascar for two weeks to assess the impact of RU activities. Global level interviews with collaborating partners and in-depth interviews and focus groups in the field were conducted with over 150 participants. Research reports, clinic data, and country guidelines were also used to measure research utilization efforts.

Findings
A focus country approach, study tours, and action oriented dissemination facilitated RU efforts in the selected countries. The impact of these efforts was noted at both the policy and program level. At the global policy level, RU efforts provided input to WHO’s Four Cornerstones for Evidence-Based Guidance for Family Planning through the Medical Eligibility Criteria (MEC), Selected Practice Recommendations for Contraceptive Use, Decision-Making Tool for Family Planning Clients and Providers and Family Planning: A Global Handbook for Providers. In Madagascar, RU efforts had an active role in ensuring that WHO guidelines informed the national norms and procedures.

RU efforts were also measured via program outputs in the field. In Kenya, RU efforts helped increase access to and use of the Intrauterine Contraceptive Device (IUCD). In Madagascar, RU efforts have catalyzed the distribution of the injectable contraceptive depot-medroxyprogesterone acetate (DMPA) by community based workers. In one district of Madagascar, community based distribution of DMPA increased from 20.9% in 2006 to 35% in the second quarter of 2008 and 16% of DMPA users obtained their method from a CBD agent. Other evidence based practices such as systematic screening to determine and meet client needs were less utilized in the field. It was unclear if this was a result of poor utilization efforts from the research CA or a lack of support from service delivery organizations.

There were some common constraints to research utilization. Effective collaboration between research organizations, service delivery organizations, and governments can be challenging due to mismatching timelines and project cycles, limited funding, ownership/ attribution, and political will.

Knowledge/Contribution/Lessons Learned
The model of incorporating research utilization efforts in a research agreement yielded some positive results. However, it is clear that this model is incomplete. Successful research utilization must also involve service delivery organizations and programs. Ultimately both service delivery and research partners are working towards the same goals. Thus, it is critical that there are better efforts to feed research results into practice and conversely, feed practice experience into research questions.

The RU assessment has sparked a number of additional activities to further understand how USAID/OPRH can ensure the use of evidence based practices among CA partners and bilateral programs in the field. These include a complementary assessment of service delivery organizations and their utilization of evidence based practices, a large assessment of research priorities for the future including utilization, and a country strategy for adoption of evidence based practices in family planning.

PS: 21
Mainstreaming Population Issue (FP/RH) in to Environmental Management Projects
Shewaye Deribe Woldeyohannes
Ethio Wetlands and Natural Resources Association, Ethiopia; shewaderibe@yahoo.com

ABSTRACT
Background:
Rapid population growth is one of the outstanding challenges to environmental management in Ethiopia. There is high dependence of poor people on natural resources such as wetlands and forests for livelihood, construction of houses, fuel, etc. This dependence, besides destroying the resilience capacity of ecosystems, it causes resource use conflicts among user groups and diminishes natural assets for further development and environmental wellbeing. As the agricultural lands lose their fertility due to poor husbandry and resultant soil erosion, more people rather larger families are converting forest areas and wetlands into crop fields. As a result of this common phenomenon, large biodiversity rich areas have been stripped in the last few decades. Despite local and global initiatives to tackle the prevailing environmental and socioeconomic crisis the problem continued to mushroom in different areas. One of the major reasons for this is lack of integrated approach among the actors at least at planning stage and joint resource mobilization to break the root cause.

Intervention/Activity Tested
Ethio Wetlands and Natural Resources Association (EWNRA) has been integrating at household and community level efforts that address environmental, livelihood, food, health and population issues in its Integrated Wetland-Watershed Management Projects being implemented in different sub-watersheds since 2005. One of the pioneer projects is “Integrated Wetland-Watershed Management Project” which has been implemented in the Wichi Watershed, Metu Woreda (2005-2008), in south west Ethiopia through financial assistance of SLUF/SIDA. This area is home for biodiversity rich remnant rain forests of the country. Core points of the projects of the EWNRA are improving human and ecosystem wellbeing through harmonizing the interaction between people and their environment.

Methodology:
The approach being employed in project implementation basically includes:
- Baseline assessment of target project area and communities through field observation, participatory rural appraisal and sample house to house interviews to prioritize and identify major problems,
- Promote awareness/training and participation of stakeholders in planning, implementation, monitoring and evaluation
- Establish strong community structure that owns and oversees project progress (community based organization with watershed committee and by law)
- Implement package of interventions:
  - activities that improve ecosystem capacity,
  - Activities that improve farm land productivity and food security,
iii. Activities that improve livelihood, health, save women’s time and energy and promote family planning (These are entry point activities with value added results e.g. clean water schemes, revolving fund, fuel saving stove directly affecting women)

Invite Local health office experts on Family planning and HIV/AIDS awareness programmes

Invite local Water office for Water and Sanitation training,

Findings/Results:

The number of couples in reproductive age who are using family planning is increasing from time to time; For instance local health centre, from its family planning coverage assessment in eight villages, has reported that family planning coverage on average reached 54.9% (average of four sample sites within the project areas of EWNRA) and 22.15% (in four sites outside of the EWNRA project sites).

Water borne diseases such as diarrhoea reduced in households that use clean water from 49 clean water schemes installed (health station data indicate highly reduced diarrhoea cases from the project intervention areas) (for instance the same report from the same sites indicated 14.2% diarrhoea prevalence outside the project sites and on average 1.3% within the project intervention area of the EWNRA).

The knowledge of more than 2500 householders (supporting more than 13,000 individuals) improved in land husbandry, water and sanitation and environmental issues, Farmland productivity, food quality and quantity, and livelihood of the community improved, and their vulnerability reduced, Wichi wetland (364 hectare) and its watershed more than 2800 hectare core area and some 8000 hectare surrounding rehabilitated,

Knowledge Contribution:

The integrated wetland-watershed approach has resulted in chain of results that support each other at community and household level. For instance activities which are designed to improve water and sanitation, income generation and fuel wood saving have opened opportunities for women empowerment, saving time and energy of young girls and thereby their better performance in school and also opened forum to convey family planning and HIV/AIDS related knowledge to women. Clean water points are becoming convenient areas to convey family planning and health/sanitation messages to women and young girls. Moreover, better land management work (using Compost and Vetiver grass) and crop diversification have improved food quantity and quality (nutrition status) and reduced the pressure on the environment (deforestation and wetland conversion for more land). This approach has contribution both to the health of people and the environment. Thus from our practice being in progress we are learning that it is possible to address environmental, population, health and livelihood issues through community based integrated interventions at watershed level.

PS: 22

Capitalizing on the Opportunity to Integrate SRH into HIV/AIDS Proposals under GFATM: Do Recent Proposals Reflect the Evidence Base?

Karen Hardee1, Jill Gay2

1Population Action International, United States of America; 2Consultant; KHardee@popact.org

1. Background/Significance

Starting with Round 7 and more explicitly in Round 8, the Global Fund for AIDS, Tuberculosis and Malaria (Global Fund) has included guidance that countries can include sexual and reproductive health (SRH) in their proposals as long as the country can demonstrate an impact on one of the three disease outcomes. This development represents a tremendous opportunity that has long been advocated by a range of organizations that promote strengthened linkages and integration of SRH, including family planning and HIV in country programs. Evidence is building that linkages and integration can make a difference to both HIV and SRH outcomes.

2. Research: State Main question/hypothesis

How are countries responding to this opportunity to link and integrate SRH and HIV/AIDS in their proposals to the Global Fund? Are countries using evidence on the effects of integration to inform their proposals? This paper analyzes successful proposals Rounds 7 and 8 and presents the components of integration that have been proposed by countries, including plans for monitoring and evaluating the integrated programs. The paper also presents the evidence of integration that have been found to affect HIV/AIDS outcomes to assess the match between evidence and proposed interventions. Finally, the paper discusses the likely challenges countries will face in implementing the integration components of their proposals.

3. Methodology: Location, setting, period, analysis approach

The authors searched the Global Fund website using the terms “reproductive health” and “integration” and reviewed lists of approved proposals for Rounds 7 and 8. Other relevant documents from the Global Fund and other organizations working on integration were also reviewed. The authors also conducted an extensive literature review of the evidence related to SRH/HIV integration using Medline, Popline and SCOPUS, as well as reviewing documents from key websites such as UNAIDS and WHO, among others.

4. Data

Data were gathered using the relevant proposals submitted to the Global Fund that included SRH integration into HIV/AIDS proposals and the evidence base to support integration (see methodology for scope of the review).

5. Findings

Global Fund awarded proposals have included some of the following SRH/HIV integration interventions; peer education for key populations on SRH and HIV prevention; offering VCT together with family planning; training midwives on VCT and family planning; providing SRH education for women living with HIV and their partners; integrating SRH/HIV services; providing post-exposure prophylaxis (PEP) for rape survivors; procuring family planning commodities for PMTCT programs; integrating family planning counseling in PMTCT programs; training community health workers on HIV and family planning; incorporating HAART into PMTCT programs; providing family planning counseling and methods for women living with HIV; and providing female condoms.

Review of the literature provides evidence that SRH/HIV integration, when applied in particular epidemiologic settings, can contribute to: reducing maternal mortality from HIV/AIDS; reducing unintended pregnancy and perinatal transmission; increasing VCT to more groups of people who may be at risk but who have not been reached; increase access and use of HIV services; and reduce gender-based violence which increases risk for HIV acquisition. Selected proposals have included some of these elements in SRH/HIV integration, but much more could be done to promote evidence-based SRH/HIV integration in future proposals which could have a significant impact on the HIV/AIDS pandemic. Most notably, reducing unintended pregnancy will have a significant effect on reducing perinatal transmission of HIV. In general, country proposals have inadequately included programming to address multiple
concurrent partnerships; promoting dual protection; providing women living with HIV the safest ways to become pregnant to reduce PPT; in countries where abortion is legal, providing referral to VCT; changing laws to allow victims of marital rape to access PEP; and linking PMTCT programs with rape survivor services, among other missed opportunities. Most of the proposals have weak monitoring and evaluation of their SRH/HIV integration, with few proposed indicators to monitor progress.

6. Knowledge Contribution

Considerable evidence exists to support the contribution of integration of SRH into HIV/AIDS services and interventions. Some recent proposals submitted to the Global Fund have used evidenced-based SRH/HIV integration interventions. Yet critical interventions are still not part of any Global Fund proposals. Furthermore, evaluation of the implementation of currently awarded SRH/HIV integrated proposals is vitally important to continue to expand the evidence base for integration and to provide information to review and improve existing integrated programs.

PS: 23

Using the RAPID Model for Engaging Local Governments to Reposition Family Planning in Tanzania

Gregory Kamugisha, Millicent Obaso

Futures Group International, Tanzania/Health Policy Initiative, Tanzania; GKamugisha@futuresgroup.com

Background: The need for expanded family planning (FP) services in Tanzania cannot be overemphasized. In fact, prospects for achieving most of the objectives set forth in the country’s development planning documents—such as the Tanzania Development Vision 2025, the National Strategy for Growth and Reduction of Poverty, the National Population Policy of 2006, the Maternal and Newborn Strategy (2007–2012), and others—are dependent on what happens to the current reproductive health (RH) situation.

Low modern contraceptive prevalence (20%) is contributing to the challenges in maternal and child health as well as socioeconomic development. The maternal mortality ratio has risen to one of the highest in the world, from 529 deaths per 100,000 live births in 1996 to 578 per 100,000 live births in 2004/5. Young women are at even higher risk because two-thirds of women (63%) are married by age 20 and almost two-thirds women age 20-24 are sexually active by the age of 18. Approximately 68 infants (under 12 months) die for every 1,000 live births and approximately 112 children under 5 die for every 1,000 live births. Infant and child mortality rates would be lessened by increased use of family planning. The rapid population growth rate caused by high fertility, at 2.9 percent per annum, suggests that the population size will double in just 25 years, which burdens the already stretched social services and natural resources. With continued rapid population growth, the economy will not be able to provide the needed level of services.

Program Intervention / Activity Tested: Based on the Law Government Act (1982), District Councils in Tanzania are mandated to set development plans, implementation strategies, and budgets to finance locally prioritized activities. The USAID Health Policy Initiative, Task Order 1, started an advocacy campaign targeting Local Governments to seek enhanced integration of population issues into District Councils’ plans, particularly by expanding FP budgets and services.

Methodology: Since 2006, the Health Policy Initiative has partnered with in-country stakeholders, particularly the Population Planning Unit of the Planning Commission/President’s Office, to strengthen commitment for FP programs in Tanzania. A major component of this effort is evidence-based advocacy using the RAPID Model—a computer model contained in the Spectrum Suite. RAPID combines socioeconomic indicators with demographic information and population projections to estimate future needs. The model projects different scenarios so that policymakers can compare the consequences if the country/district continues to have high fertility and the benefits of reducing fertility through FP programs. The analysis was packaged in booklets, in the name of the Population Planning Unit, for ease of dissemination together with a PowerPoint presentation illustrating the step-by-step analysis.

Between April and September 2008, the Health Policy Initiative in partnership with the Population Planning Unit and master trainers disseminated the RAPID package, reaching 116 officials from 34 districts across the regions of Dar es Salaam, Dodoma, Morogoro, Lindi, Mtwara, and Coast (Pwani). Participants included district health officers, planning/budget officers, and statisticians. Participants were oriented on the links among FP/RH, population, and development and trained on adapting RAPID to their districts.

Findings: The trained district officials acknowledge the challenges posed by rapid population growth and committed to push for the integration of population issues into district planning, particularly by seeking increased public resources for FP services. They also shared feedback that is helping improve the program: (i) There is need for strengthening and harmonizing data collection systems at district level to improve development planning; (ii) District FP services are highly under-funded partly because they fall under “Reproductive Health” section in the national and district health budget, which is considered precautionary in nature, while the government traditionally spends more on treatment services; (iii) FP advocacy messages should also be directed to national political leaders to make FP a national priority; (iv) Additional advocacy messages need to be directed to decisionmakers with control over public budgets such as District Executive Directors, Councilors, and Heads of District Councils’ Department; (v) Possibly related to resource limitations, FP services at districts are affected by regular commodity stock outs, limited method choices, staff insufficiency, and inadequate supervision, M&E, and coordination. Therefore, apart from mobilizing more resources, delivery systems need to be strengthened significantly.

Program lessons learned: The process was largely facilitated by: (i) The dialogue being hosted by the Population Planning Unit of the government helped acceptability of the program to district officials; (ii) It is important to understand specific circumstances of each district in setting development plans; (iii) Building the case on in-country developed documents, such as the National Population Policy, the Tanzania Development Vision 2025, and the National Strategy for Growth and Reduction of Poverty, helped to make district officials see the importance of the presented issues; and (iv) Many district officials did not initially know about the significant contribution of FP to improving maternal and child health.

PS: 24

Les besoins non satisfaits et les besoins satisfaits en matière de planification familiale au Congo : Niveaux et déterminants

Frédéric Nkeoua

Association Congolaise pour le Bien-Etre Familial, Congo; fnkeoua@yahoo.fr

Les femmes au Congo représentent un peu plus de la moitié de la population totale (52%) et celles qui sont en âge de procréer environ 20%. Les principaux indicateurs calculés à partir des données de l’Enquête Démographique et de Santé du Congo (EDSC, 2005) sont préoccupants. Il s’agit notamment de:

• Indice synthétique de fécondité 4,8 enfants par femme (3,1 en milieu urbain et 6,1 en milieu rural);
• Taux de mortalité maternelle 781 décès maternels pour 100.000 naissances vivantes et;
• Taux de prévalence contraceptive par les méthodes modernes 13%.
• Proportion des femmes ayant déclaré avoir eu recours à l’avortement au cours de leur vie 11%.
Malgré le rôle primordial de la planification familiale dans la réduction des niveaux de mortalité maternelle et infanto-juvénile, aucune étude n’a été réalisée au Congo sur les besoins non satisfaits en matière de planification familiale (BNS en PF). Pour éclairez les facteurs responsables du niveau élevé des BNS, une étude approfondie portant sur les femmes de 15-49 ans a été réalisée à partir des données de l’EDSC.

Comme hypothèse de recherche, nous supposons que c’est le faible pouvoir de négociation de la contraception par la femme au sein du couple, déterminé par les inégalités socioculturelles et socio-économiques et les différences démographiques, qui agit de façon prépondérante sur l’occurrence des BNS en matière de PF. Nous avons procédé à deux types d’analyse, une analyse descriptive simple pour étudier les niveaux et différentiels des BNS en matière de PF et une analyse multivariée en vue d’identifier, toute chose égale par ailleurs, les principaux déterminants des BNS en matière de PF.

Il ressort des analyses que la prévalence des BNS en PF est faible, soit 10,2 % pour l’ensemble des femmes dont 16,2 % parmi les femmes en union et 2,4 % chez les hors union.

La propension à exprimer les BNS en PF augmente notamment en l’absence de la discussion de la contraception entre conjoints, en présence d’une descendante élevée (6 enfants et plus), en présence du chômage et lorsque l’âge de la femme augmente. En revanche, l’amélioration de l’instruction de la femme tend à réduire sa propension à présenter des BNS en matière de PF. Cependant, l’approbation de la PF par la femme pese très peu sur les décisions en matière reproductive en général et sur la réduction des besoins non satisfaits en PF en particulier. Tout compte fait, la décision en matière de procréation et de PF dépend encore largement, dans le contexte congolais de l’homme mais aussi de la famille.

CB01: The Missing Link: The Management of Change to Scale Up Effective Practices

**Time:** Wednesday, 18 November 2009: 2:00pm - 3:30pm

**CB01: 1**

**The Missing Link: The Management of Change to Scale Up Effective Practices**

**Tim Allen**

MSH; richeyc@who.int

**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

Facilitated by: Tim Allen, MSH; Joan Mansour, MSH; Maggie Usher-Patel, WHO/RHR; Nandita Thatte, USAID; Jason Smith, FHI

**CB02: Using FP Tools: WHO Guidance and Provider Checklists**

**Time:** Wednesday, 18 November 2009: 2:00pm - 3:30pm

**CB02: 1**

**Using FP Tools: WHO Guidance and Provider Checklists**

**Eva Canoutas**

FHI; richeyc@who.int

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.

Facilitated by: Eva Canoutas, FHI

**CB03: Scaling Up From the Start: Beginning with the End in Mind**

**Time:** Wednesday, 18 November 2009: 2:00pm - 3:30pm

**CB03: 1**

**Scaling Up From the Start: Beginning with the End in Mind**

**Trinity Zan**

FHI; richeyc@who.int

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

Facilitated by: Trinity Zan, FHI

CB04: Reality Check: A Forecasting Tool for Evidence-Based Planning and Advocacy

Time: Wednesday, 18 November 2009: 2:00pm - 3:30pm

CB04: 1

Reality Check: A Forecasting Tool for Evidence-Based Planning and Advocacy

John Pile
EngenderHealth; richeyc@who.int

Description: 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 V, 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, adopts, commodities, commodity costs, and service-delivery capacity, based on demographic data. Reality V 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.

Target Audience: Program planners and managers; family planning officials in donor agencies and NGOs; ministry of health officials.

Facilitated by: John M. Pile, EngenderHealth

CB05: Tips and Tools for FP Advocacy

Time: Wednesday, 18 November 2009: 2:00pm - 3:30pm

CB05: 1

Tips and Tools for FP Advocacy

Rhonda Smith
World Health Organization, Switzerland; richeyc@who.int

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.

Facilitated by: Rhonda Smith, PRB and Freddie Sengooba

CB06: Documentation of "Practices that Make Programmes Work"

Time: Wednesday, 18 November 2009: 2:00pm - 3:30pm

CB06: 1

Documentation of "Practices that Make Programmes Work"

Suzanne Reier
WHO/IBP; richeyc@who.int

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

Facilitated by: Suzanne Reier, WHO/IBP; Maureen Kuyoh, FHI/Kenya; Solomon Marsden, FHI/Kenya

CB07: "Social Analysis and Action" Approach

Time: Wednesday, 18 November 2009: 2:00pm - 3:30pm

CB07: 1

"Social Analysis and Action" Approach

Azum Ciloglu
CARE; richeyc@who.int

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.

Facilitated by: CARE representatives

CB08: Improving Technical Assistance with a Focus on Evidence-Based Practices

Time: Wednesday, 18 November 2009: 2:00pm - 3:30pm

CB08: 1

Improving Technical Assistance with a Focus on Evidence-Based Practices

Nandita Thatte
USAID; richeyc@who.int

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

Facilitator to be announced

CB09: Female Condom Programming

Time: Wednesday, 18 November 2009: 2:00pm - 3:30pm

CB09: 1

Female Condom Programming

Ilze Smit, Lucie van Mens, Hendrick Salla, Victoria Archibong
Universal Access to Female Condoms Joint Programme; richeyc@who.int

The skill building workshop on female condom programming 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?

Facilitator to be announced.
AUXILIARY MEETING AND WORKSHOP DESCRIPTIONS

Saturday, 14 November 2009

Saturday, 14 November 2009, 9:00am-5:00pm, Majestic Hall

Bringing New People to Family Planning: Fertility Awareness Methods
Workshop for Trainers
Institute for Reproductive Health, Georgetown University
Contact: Ms. Dina Abi-Rached, da262@georgetown.edu

The Institute for Reproductive Health at Georgetown University (IRH) has organized a one day workshop to offer trainers, both familiar with and new to fertility awareness methods (FAM), a forum to learn about and discuss FAM and its integration into existing training and services. The goal of this workshop is to strengthen the capacity of a cadre of master trainers to support integration of the Standard Days Method® and Lactational Amenorrhea Method into existing training.

Sunday, 15 November 2009

Sunday, 15 November 2009, 10:00am-4:00pm, Emerald Hall

Building African Leadership on Population and Climate Change
Population Reference Bureau
Contact: Jason Bremner, jbremner@prb.org
By Invitation Only

The goal of this workshop is to create a cadre of African professionals, researchers, and policymakers who are knowledgeable about the linkages between population, climate change, and adaptation, and who are empowered to participate in discussions of the role of social adaptation strategies, including family planning, in national action plans and organizational strategies that address climate change. The workshop is being organized by the Population Reference Bureau with contributions from Population Action International and other experts.

Sunday, 15 November 2009, 10:00am-12:00pm, Room TBD

Sharing the Results of the Study of the Implementation of the Maputo Plan of Action (MPOA) in Africa - Level of the Implementation of MPOA
International Planned Federation Africa Regional office
Contact: Cheick Ouedraogo, couedraogo@ippfaro.org

The purpose of the session is to share among partners the results of the study on the implementation of the Maputo plan of action (MPOA) in Africa, build solid networks around the acceleration of country implementation of the MPOA to meet the objectives of the continental policy framework for SRHR.

This study was conducted in collaboration with all Partners working on the substantive issue at country. The rationale for discussing the matter rests on the need to re-invigorate the implementation of the MPoA and report on progress towards the attainment of the MDGs. By way of sharing the level and outputs of the implementation of the MPoA towards the achievement of the health related MDGs in Africa, the international community will be updated about potentials, weaknesses, national priorities and efficient use of resources in countries towards the achievement of universal access to SRHR. The evidence generated will be used to mobilise more resource and advocate for high political commitment at countries level to boost the implementation at countries level. By the same token, the session will help highlight some major processes and best practices regarding the implementation of the MPoA. Presenters, key discussants will include UNFPA, AU and IPPF.
Sunday, 15 November 2009, 1:00-3:00pm, Room TBD

Launch of the Women Leaders Initiative
International Planned Federation Africa Regional office
Contact: Josephine Mutingi, jmutingi@ippfaro.org

The IPPF Africa Region in collaboration with the Packard Foundation will launch an initiative that aims to harness African women’s leadership to advocate for increased national and regional commitments in policies, laws and budgetary allocations for sexual and reproductive health.

The project titled ‘Mobilizing African Women Leaders to Promote Sexual and Reproductive Health’ seeks to establish a robust network of African women leaders from throughout the continent to influence positive and tangible change in national and regional commitments to sexual and reproductive health and rights. The network is expected to translate the collective voices of women’s leaders through vibrant and visible advocacy interventions at national and regional levels.

The meeting will introduce the project to key stakeholders attending the International Family Planning Conference, including women leaders, researchers, service providers, government officials, development partners, media, and engage them in discussions on how best to operationalize and sustain the network.

Monday, 16 November 2009

Monday, 16 November 2009, 8:30am-5:30pm, Commonwealth Banqueting Hall
Financing Health-related Millennium Development Goals: Challenges and Opportunities
Contact: Jotham Musinguzi, jmusinguzi@ppdsec.org
Closed meeting, by invitation only

Financing Health-related Millennium Development Goals: Challenges and Opportunities is a one-day Africa-focused, senior policymaker seminar to be held on Monday, November 16, 2009. The seminar is sponsored by Partners in Population and Development, the African Union, and the World Bank and runs concurrent with other research sessions of the International Conference on Family Planning from November 15-18, 2009 in Kampala, Uganda. The seminar is not open to the public.

The seminar will bring together over 100 participants including ministers of finance, health, economic planning, members of parliament, women leaders, and knowledgeable civil society leaders (physicians, faith, corporate sectors) in the sub-Saharan African region. The objectives of the meeting are to share and diffuse successful FP national experiences between countries from all regions; increase commitment and mobilization of budgetary and other resources for FP programs; and to use a Voices-of-the-South model to develop ownership of FP programs.

Monday, 16 November 2009, 6:00-7:00pm, Stables Restaurant

Marie Stopes International Cocktail Event
Marie Stopes International will host a cocktail event. Dana Hovig (CEO) will launch the MSI calculator to measure the impact of family planning programmes.

Monday, 16 November 2009, 7:00pm, Majestic Hall

Costing for Scale Up: A Skills-Building Workshop
Family Health International
Contact: Kate H. Rademacher, krademacher@fhi.org

During this interactive workshop, participants will learn how to estimate costs when reproductive health innovations are scaled up. Often, program managers and policymakers mistakenly assume that estimating the cost of running a program at scale simply involves multiplying the costs of the pilot project by the number of proposed sites in the scale up scenario. Instead, incremental analysis is required to assess the costs of scaling up. Planners must determine which pilot costs will be applicable at
scale, and which costs will increase or decrease when an innovation is expanded or replicated. After completing the workshop, participants will be able to: 1) identify the steps involved in costing a pilot intervention; 2) understand that scale up costs cannot be computed with simple multipliers of pilot costs; 3) identify ways that pilot costs differ from costs when an innovation is taken to scale; and 4) estimate costs of scaling up. Participants will apply new knowledge and skills during the workshop by completing an in-depth case which includes several costing exercises. The case is based on a scenario involving a FP/HIV integration initiative in fictitious east African health clinics.

Monday, 16 November 2009, 7:00-8:30pm, Albert Hall

Maximizing the Contribution of Family Planning through the First Year Postpartum
Jhpiego
Contact: Angela Nash-Mercado, anash-mercado@jhpiego.net

Postpartum family planning (PPFP) has important implications for FP service delivery. This workshop will share experiences, tools and lessons learned from field-based programs implemented by ACCESS-FP, a USAID global associate award led by Jhpiego with the mandate of reducing unmet need for family planning among postpartum women. Participants attending this workshop will have opportunities to interact with PPFP experts through presentations and hands-on demonstrations. The workshop will start off with an overview of PPFP, including the rationale, content, and global best practices, followed by five featured demonstrations. Participants will then choose 3 out of 5 concurrent demonstrations to attend. The demonstrations will include: 1) lactational amenorrhea method (LAM) and transition; 2) postpartum IUCD insertion; 3) postpartum tubal ligation; 4) PPFP resources and advocacy; and 5) Country experience: introducing postnatal care and family planning (PNC/FP) in Kenya. The closing remarks will then highlight key messages and programmatic considerations for implementing PPFP programs.

Monday, 16 November 2009, 7:00-8:30pm, Sheena Hall

Female Condom Programming: breaking down the barriers!
Universal Access to Female Condoms’ UAFC Joint Programme
Contact: Ilze Smit, i.smit@wpf.org

Because many people judge the female condom without ever seeing, let alone using one, we will give a female condom demonstration. The different prejudices will be discussed with the audience while showing the different female condom models.

- Research findings on female condoms and female condom programming will be presented to ground the statements on evidence. Studies on the acceptability and effectiveness of female condom programming give insights in the need for the female condom.
- On the other side, barriers and challenges (lack of comprehensive programming, lack of variety, the current procurement price of the female condom, need for demand creation, supply chain management) will be discussed.
- Breaking down the barriers by implementing a large-scale female condom programme: the best practices of ‘Universal Access to Female Condom’ (UAFC) Joint Programme in Nigeria and Cameroon.

Monday, 16 November 2009, 7:00-9:00pm, Meera Hall

Developing Cost-Effective Interventions to Increase Modern Contraceptive Use: Insights and Challenges from Nigeria and India
African Population and Health Research Center
Contact: Jean Christophe Fotsot, jcfotsot@aphrc.org

The Bill and Melinda Gates Foundation’s Urban Reproductive Health Initiative (URHI) aims to increase modern contraceptive use in selected urban areas of five countries in sub-Saharan Africa (Nigeria, Kenya and Senegal) and South Asia (India and Pakistan). Key elements of the Initiative include 1) integrating of FP services with maternal and newborn health and HIV/AIDS services; 2) improving the quality of FP services; 3) increasing FP access through public-private partnerships; and 4) creating sustained demand for FP services among the urban poor. While the Initiative will be designed and implemented by country-based consortiums, the Measurement, Learning and Evaluation (MLE) project will use state-of-the-art methods to evaluate the impact of the Initiative on modern contraceptive use and examine related questions such as inequities and pathways leading to the observed increase.
The goal of the workshop is to: 1) present the URHI in India and Nigeria and highlight the opportunities and challenges; 2) describe the MLE design, framework and plans; 3) present plans for dissemination of findings and best practices—including but not limited to the project’s website; and 4) get wider inputs, comments and suggestions from workshop participants. A cocktail reception will be served at the beginning of the workshop.

Monday, 16 November 2009, 7:00-9:00pm, New Hall 1

Leaping the Hurdles and Navigating the Maze: Getting Funding from NIH
US National Institutes of Health, Center for Population Research
Contact: Susan Newcomer, newcomes@mail.nih.gov

Dr. Newcomer, a staff member at the US NIH, will outline the NIH and its general approach to soliciting, reviewing and funding research on contraceptive use and reproductive health. She will provide tips on grant writing.

Monday, 16 November 2009, 7:00-9:00pm, New Hall 2

Stronger Health Systems for Family Planning
Management Sciences for Health
Contact: Laura Sider-Jost, lsider@msh.org

No description available.

Tuesday, 17 November 2009

Tuesday, 17 November 2009, 6:30-8:30pm, Meera Hall

How to Expand Community-Based Access to Injectable Contraceptives: Tools for Program Managers
Family Health International
Contact: Morrisa Malkin, MMalkin@fhi.org

This workshop is intended to help health officials and managers of community-based family planning programs prepare for, advocate for and implement community-based distribution (CBD) of injectable contraceptives in their countries and communities.

A fun, interactive workshop format will orient participants to tools, job aids and other resources that can assist them in adding injectables to their current CBD program or in strengthening their existing CBD of injectables program. Two examples of implementation tools are a new standardized training curriculum for CBD agents and a step-by-step program implementation guide. This south-to-south forum provides an opportunity to exchange knowledge and experiences around CBD of injectables. Participants can learn from and ask questions of programmatic experts from countries that have already implemented CBD of injectables.

The workshop is from 19.00 - 20.30 hrs. Prior to the workshop, a hors d'oeuvres reception will be held from 18.30 - 19.00 hrs.

Tuesday, 17 November 2009, 7:00-9:00pm, Victoria Ballroom

IBP Technology Café
World Health Organization, Implementing Best Practices Initiative
Contact: Maura Graff, mgraff@jhsph.edu

A Technology Café is an interactive session that provides organizations and agencies with the opportunity to showcase, demonstrate and discuss their electronic tools and media, such as web sites, CD-ROMs, communities of practice, and eLearning courses. Participants will have the opportunity to gain hands-on experience using these tools with guidance from a facilitator.
Tuesday, 17 November 2009, 7:00-9:00pm, Majestic Hall

From Family Planning Research to Public Policies in Africa: Strategic Campaign Imperatives
*AfriCan Population and Health Research Center*
Contact: Charles Okigbo, cokigbo@aphrc.org

This workshop is designed for researchers, program officers and administrators who are interested in the little-understood processes and strategies for translating research results into public policies, using strategic advocacy campaign approaches. Much of our valuable research results in family planning should lead to actionable public and private policies to improve the lives of our people. Unfortunately, this is not the case now. This workshop provides a broad introduction with specific illustrations of advocacy campaign strategies that can be used to influence policy makers in family planning and related health areas. The major topics covered are: Advocacy campaign philosophy, strategic planning, campaign strategies and tactics, the 13-step process, relevant communication theories, persuasion, integrated marketing communications, and why some campaigns fail. Some attention will be paid to the role of leadership in organizational effectiveness. This workshop is designed to appeal to participants from a wide range of academic and professional backgrounds and no prior knowledge of advocacy, public affairs or public policy making is required to learn from and participate actively in the presentation. A short reading list will be provided along with lecture slides. Professor Charles Okigbo, APHRC, Kenya and North Dakota State University, Fargo.

Tuesday, 17 November 2009, 7:00-8:30pm, Regal Hall

Models for Policy and Advocacy
*Futures Group International*
Contact: Suneeta Sharma, ssharma@futuresgroup.com

This session provides an introduction to Policy and Advocacy models for family planning. The models are part of the Spectrum suite of policy models, which uses a unified set of Windows-based commands that are easy to master. We will focus on six models: DemProj, FamPlan, AIDS Impact Model (AIM), RAPID, Safe Motherhood Model, and Allocate. DemProj projects the population of a country or region by age and sex and provides the demographic inputs required for other Spectrum models. FamPlan projects family planning requirements to reach national goals for addressing unmet need or achieving desired fertility. AIM examines the consequences of the HIV epidemic, including the number of people living with HIV, new infections, orphans, and AIDS deaths by age and sex. RAPID projects the social and economic consequences of high fertility and rapid population growth for such sectors as labor, education, health, urbanization, and agriculture. Safe Motherhood Model helps managers to gain a better understanding of the impacts of policies, budgets, and service delivery improvements on maternal health outcomes, particularly the country’s maternal mortality ratio. Finally, Allocate examines the linkages and interactive impacts of changing decisions about funding levels for FP, safe motherhood, and postabortion care. Participants will learn the data needs and outcomes of all six models, while looking at results from country-specific applications.

Tuesday, 17 November 2009, 7:00-10:00pm, Albert Hall

Community and Social Change in Adolescent Sexual and Reproductive Health and Family Planning Programs: Strategies for Measuring Change
*International Youth Working Group: Pathfinder International, CARE, Jhpiego, UNFPA, Georgetown University/Institute for Reproductive Health*
Contacts:
   Cate Lane, Pathfinder International, clane@pathfind.org; Susan Igras, GU/IRH, Smi6@georgetown.edu

Family planning programs that include significant community participation yield more positive results, especially in regards to community norms and values that influence sexual and reproductive health, such as appropriate age of marriage and first birth, child spacing practices, use of available services and quality of care. Sexual and reproductive health behavior change (such as increased use of family planning methods) is more likely to be sustained in communities that undergo normative change. The Interagency Youth Working Group (especially Pathfinder International, Advocates for Youth, CARE and UNFPA) developed Community Pathways to Improved Adolescent and Sexual Health: A Conceptual Framework and Suggested Outcome Indicators. While this document was specific to adolescents, the concepts are broad and can be applied to a number of populations where there is significant unmet need or high rates of method discontinuation. Importantly, indicators that measure community involvement for improved health outcomes are presented. The workshop will present this framework, as well as relevant experiences from CARE, Pathfinder Kenya, UNFPA and ACCESS FP (and possibly Save the Children) that show has this framework
or other community involvement methodologies (such as Community Action Cycle) have been operationalized in programming and the results that have been achieved. Importantly, the workshop will provide participants with new skills in developing, implementing and assessing effective community involvement strategies. Participants will have an opportunity to first apply the framework to a case study (which will be developed by the workshop collaborators). As time permits, participants will be encouraged to apply the framework to their own programs by identifying possible strategies and activities to strengthen community involvement that is linked to health outcomes, and selecting indicators to measure community involvement, with the assistance and expertise of the workshop facilitators.

**Tuesday, 17 November 2009, 7:00-9:00pm, New Hall 1**

**Round-Table Discussion about the Role and Expansion of Menstrual Regulation**
*Venture Strategies for Health and Development*
*Contact: Nadia Diamond-Smith, ndiamondsmith@venturestrategies.org*

Menstrual regulation (M.R.) is bringing on a late menstrual period without knowing whether a woman is pregnant or not. It can be achieved with either manual vacuum aspiration or misoprostol. M.R. was initiated in the United States in the 1960s. The term was adopted in Bangladesh in the 1970s, where it continues today as a legal procedure. In contrast, abortion in Bangladesh is still not legal. M.R. has spread to urban Indonesia and parts of India. Join us for a round-table discussion on the state of menstrual regulation today, and we will brainstorm about the potential for making it available for women in additional countries. Dr. Malcolm Potts, a pioneer of M.R., will open the discussion. We will invite the group to ask questions and share their experiences or views about M.R. in their country or setting. We hope to foster a lively discussion about opportunities for expanding awareness of M.R. Light refreshments will be served.

**Tuesday, 17 November 2009, 7:30-9:00pm, New Hall #2**

**Population and Reproductive Health at the World Bank: 2010-2015**
*World Bank*
*Contact: Seemeen Saadat, ssaadat@worldbank.org*

This session will focus on the World Bank’s draft Action Plan on Population and Reproductive Health 2010-2015. The purpose of the Action Plan is to rapidly operationalize the population and reproductive health component of the Bank’s 2007 Health, Nutrition, and Population (HNP) Strategy. It emphasizes strengthening key interventions for better maternal and reproductive health outcomes within health systems strengthening (HSS). This includes EmOC, pre and post natal care, provision of family planning services, and where permitted, abortion and post abortion care. It also underscores the need for an approach to population and reproductive health which goes beyond health systems strengthening in recognition of the importance of other socio-economic determinants such as education and gender equity. The Action Plan is being prepared on the recommendation of the Bank’s Executive Board, and will be presented to the Board early next year. The purpose of this session is to have a discussion on the plan as part of a larger consultative process on the Action Plan.

**Wednesday, 18 November 2009**

**Wednesday, 18 November 2009, 10:00am-12:00pm, Regal Hall**

**STEPS: Steps to Transforming Evaluation Practice for Social Change Workshop**
*Margaret Sanger Center International, Planned Parenthood New York City*
*Contact: Jacqueline Hart, Jacqueline.Hart@ppnyc.org*

STEPS (Steps to Transforming Evaluation Practice for Social Change) is a program planning, monitoring and evaluation toolkit, developed by Margaret Sanger Center International, at Planned Parenthood of New York City, and funded by the Ford Foundation and the World Bank reproductive health program. STEPS grew out of a shift in international development goals, from a narrow focus on family planning services and population control, to a broader rights-based social justice perspective on sexual and reproductive health (SRH) that emphasizes empowering women and gender equality. This workshop will provide an overview of how STEPS can help organizations develop and evaluate sexual and reproductive health and rights (SRHR) interventions. We will demonstrate how STEPS can assist in breaking down women’s empowerment and gender equality into
measurable and locally relevant components that can be the basis for programming and evaluation. STEPS emphasizes self-learning in order to make monitoring and evaluation (M&E) a meaningful and continuous aspect of the program process. It supports those who are most familiar with the program - those who directly provide services and the recipients of those services- to actively participate in M&E. STEPS is available free of charge, in both English and Spanish, on the Internet (at www.stepstoolkit.org) and on CD-ROM.

Wednesday, 18 November 2009, 11:00am-1:00pm, Majestic Hall

Expanding What We Know about Abortion and Contraceptive Use: A Workshop on an Innovative Survey Methodology

International Center for Research on Women
Contact: Susan Lee-Rife, sleerife@icrw.org
Advanced registration required; if space available, onsite registration accepted

The ICRW workshop will build skills and capacity to generate high quality data for better understanding and addressing women’s experiences and needs regarding abortion and contraceptive use. This interactive workshop will introduce participants to an innovative methodology to collect in-depth information on women's reproductive behavior, including decision-making processes, factors leading to unwanted pregnancies, and barriers to accessing services. This methodology uses a unique narrative/mixed methods approach to generate a single, large-scale survey that produces data and results that are generalizable to a broader population through standard sampling techniques. In addition, the methodology allows for the capture of this information by pregnancy interval, offering important programmatic insight into the changing needs of women throughout their reproductive life course. The improved data generated by this approach offer new possibilities for researchers to understand the motivations, constraints, and reproductive needs of women in developing countries. This workshop will provide an important opportunity to demonstrate to other researchers an effective approach for collecting the high-quality data that is essential for creating sound policy and programming on family planning and abortion.

Thursday, 19 November 2009

Thursday, 19 November 2009, 8:15am-5:15pm, New Hall 2, 3, 4

Practicum on Family Planning Communication and Advocacy Responses in Africa

AfriComNet
Contact person: Charles Kakaire, ckakaire@africomnet.org
Advanced registration required (max 80 participants)

In recognition of the need for well-designed and implemented family planning advocacy and communication programs, AfriComNet, a network of more than 900 strategic communication practitioners from 45 countries, will organize a one-day practicum. It will provide a venue for sharing successful communication and advocacy approaches, research, and tools for family planning, with a particular focus on integration with HIV/AIDS and environmental education. AfriComNet plans to bring together policy makers, donor representatives, strategic communication and advocacy practitioners, and family planning program managers for this practicum. The purposes of the practicum are to: 1) Share lessons learned, tools, and promising practices in population and FP communication and advocacy in Africa; 2) Explore the integration of family planning, population, environmental protection, and HIV/AIDS communication and advocacy; and 3) Explore communication approaches for tackling normative and cultural change required to influence family size decisions, healthy timing and spacing of pregnancies, and family planning choices.

Thursday, 19 November 2009, 9:00am-5:00pm, Sheena Hall

Sexual and Reproductive Health Advocacy and Research: Best Practices and Partnerships Meeting

Population Action International
Contacts: Suzanne Ehlers, sehlers@popact.org; Holly Greb, HGreb@popact.org
By invitation only
The Project Resource Mobilization and Awareness (PRMA) partners: International Planned Parenthood Federation (IPPF), the German Foundation for World Population (DSW) and Population Action International (PAI) will host an invitation only project meeting on Thursday November 19, 2009 to debrief on the topics raised throughout the week’s events. The meeting will explore, in greater depth, how better collaboration between researchers and advocates can result in a more complementary approach to achieving better reproductive health outcomes around the world.

Thursday, 19 November 2009, 9:00am-1:00pm, Majestic Hall

An Orientation to Modern, Fertility Awareness-Based Methods: What Every Family Planning Program Manager Needs to Know

Institute for Reproductive Health, Georgetown University
Contact: Susana Mendoza Birdsong, smm56@georgetown.edu

The Institute for Reproductive Health (IRH), Georgetown University is pleased to present an orientation on Fertility Awareness-based Methods (FAM) and their integration into family planning, health, and development programs operating in the public and private sector. Those attending the orientation will increase their knowledge of modern FAM including mode of action, efficacy, and eligibility criteria as well as training, IEC, and program resources to guide program integration of the Standard Days Method® (SDM) and the Lactational Amenorrhea Method (LAM) – within the framework of informed choice. Participants will receive copies of the newest guidelines and educational and training materials. Discussions will also focus on strategies to introduce and integrate FAM into programs. The FAM orientation draws upon the experience of previous projects in many countries in Africa and beyond, in which IRH has tested and introduced FAM in diverse family planning program settings. There will be two 2 hour sessions – one conducted in English and one in French. Everyone is welcome to attend!

Thursday, 19 November 2009, 9:00am-12:00pm, Room TBD

How to Conduct High Impact Family Planning Research

MEASURE Evaluation
Contact: Scott Moreland, smoreland@futuresgroup.com

This workshop will provide guidance on how to design and implement research activities with strong potential to inform policies, programs and services in the locations where you work? It will cover:

- How to identify program and/or policy relevant research topics.
- How to involve key decision makers in your research process.
- How to extract program and/or policy recommendations from your research findings.
- How to package and communicate research results to facilitate their use in decision making.

Participants will practice specific approaches and techniques that can be applied at each phase of the research process to improve the applicability and use of their research results. Participants will get hands-on experience using tools designed to facilitate this process. Dr. Scott Moreland from the MEASURE Evaluation Project, will share specific examples of improving research impact worldwide. The format will include plenary presentations interspersed with facilitated practicum to give participants hands-on experience applying MEASURE tools and approaches when designing and implementing research.
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