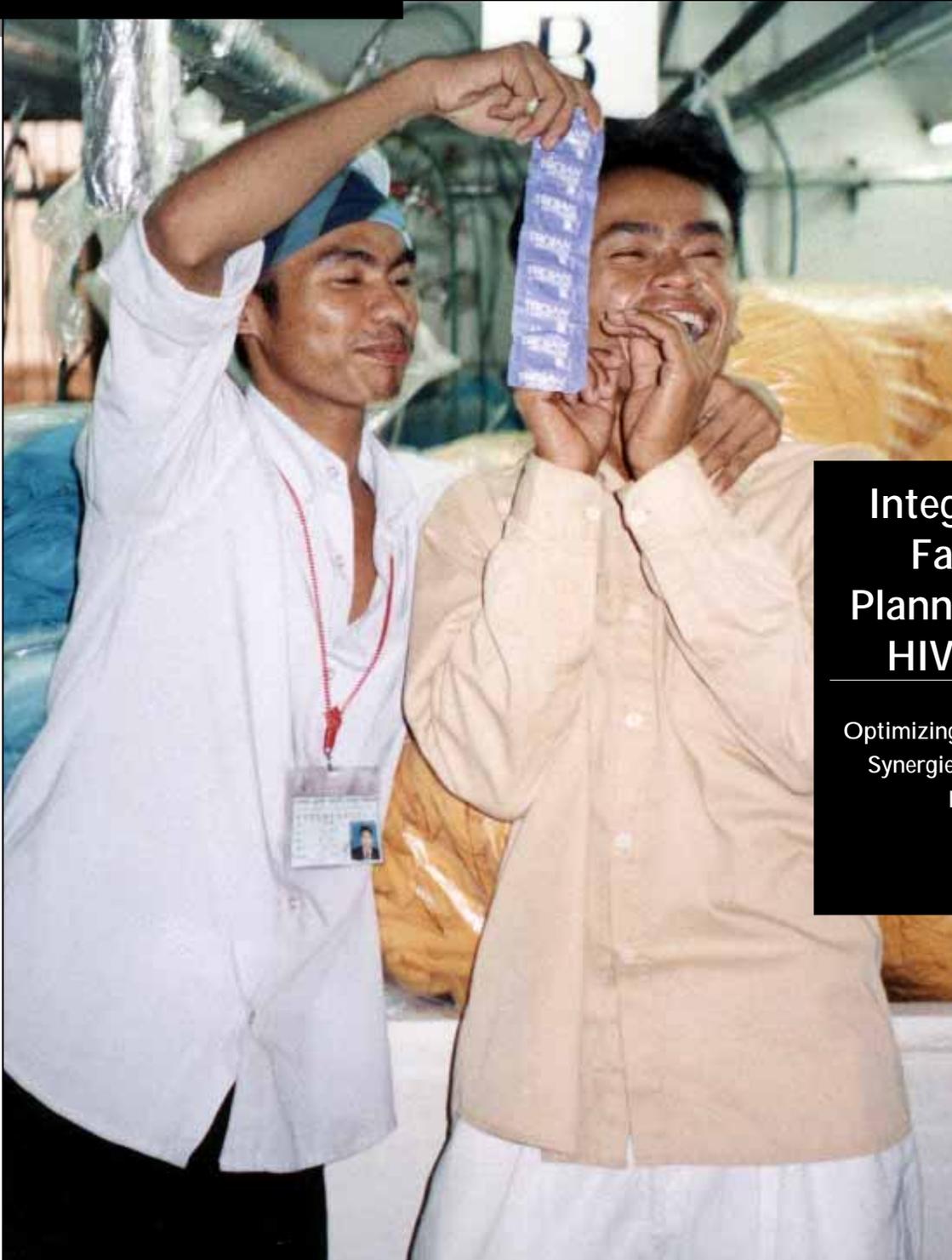


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The Inside Track

Carol Thompson has been named by President Bush to serve as the director of the White House Office of National AIDS Policy. Formerly a domestic policy advisor at the White House, Thompson became acting director following **Dr. Joe O'Neill's** appointment to the State Department Office of the Global AIDS Coordinator in August 2003. She has been termed by coworkers as "passionate" about HIV/AIDS, and has been considered instrumental in developing the five-year, US\$15 billion President's Emergency Plan for AIDS Relief.

AIDS Activists are mourning the death of **Leimapokpam Lilabanta Singh**, president of the Manipur Network of Positive People (MNP+), who died on July 21, 2004. A board member of both the Indian Network for People Living with HIV/AIDS (INP+) and the Global Network for People living with HIV/AIDS (GNP+), Singh was known for his intense activism and vision, as well as a crusader fighting for the rights of people living with HIV/AIDS and injecting drug users in India.

Kate Grant is leaving Network for Good to become executive director of the Fistula Foundation. Founded by **Richard and Shaleece Haas**, and headquartered in San Jose, CA, the foundation advocates for the treatment and prevention of obstetric fistula, a devastating childbirth injury affecting millions of women in developing countries.

Dr. Jean-Louis Lamboray, one of the founders of UNAIDS, recently announced his resignation from the secretariat because, according to the *BMJ*, he "can't continue with an institution that doesn't make a difference." Dr. Lamboray, a Belgian doctor, represented the World Bank in 1987 during the conception and design of UNAIDS. Although he praised some of UNAIDS' work, Dr. Lamboray said that it was not doing all it should and he felt the need to leave so that he could "tell the truth."

Mary Quin has been named chair of the board of the Centre for Development and Population Activities (CEDPA). The author of *Kidnapped in Yemen*, a personal account of her abduction with 15 other Western tourists by Yemeni radicals in December 1998, Quin was a delegate to the NGO Forum of the United Nations Fourth World Conference on Women in 1995.

The Organization of African First Ladies against HIV/AIDS (OAFLA) was recently formed by the wives of eight African heads of state to coordinate their efforts in combating the disease's spread. Launched in Kampala, Uganda, the OAFLA initiative will also encourage women to play a more active role in the promotion of peace and security on the continent, including activities designed to attain sustainable food security. OAFLA is comprised of the first ladies of Burundi, Comoros, Kenya, Malawi, Rwanda, Uganda, Zimbabwe and the queen of Swaziland.

JHPIEGO, an international health organization at Johns Hopkins University, has received a five-year award of \$75 million from the U.S. Agency for International Development to lead ACCESS, a program to save the lives of mothers and newborns in developing nations

Following the annual meeting of **PepsiCo Inc.'s** shareholders, the company's chairman and chief executive officer **Steven S. Reinemund** announced the company will develop a policy on HIV and AIDS by the end of the year. Although a shareholder resolution calling for a report on HIV's economic impact on the company was voted down for the second year in a row, Reinemund said PepsiCo would develop a report of its own. "HIV/AIDS is a priority for PepsiCo, and we are taking action," he said. "We will have a complete policy on HIV and AIDS by year-end, which we will be sharing publicly."



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Miss Universe 2004 Jennifer Hawkins, spokesperson for the Global Health Council's *International AIDS Candlelight Memorial*, during a site visit to the Association for the Promotion of the Status of Women in Bangkok, Thailand. Hawkins addressed the opening session of the XV International AIDS Conference, and led the audience of 12,000 in a *Candlelight Memorial* to remember those lost to HIV/AIDS, and honor and support those living with it. See page 22, for more pictures from the conference.

President Bush's daughter, **Barbara Bush**, will be interning at the Baylor College of Medicine's International Pediatrics AIDS Initiative this summer, the *Houston Chronicle* reported. Program director Mark Kline reports she plans to work at the initiative's clinics in Botswana and Uganda, as well as a clinic planned for South Africa. Barbara and first lady Laura Bush visited the pediatric clinic — which is a partnership among Bristol-Myers Squibb, the Baylor initiative and Botswana's government — during the president's five-day, five-country trip through Africa.

Pathfinder International announced that it has received a US\$8.5 million grant to support HIV/AIDS prevention programs for vulnerable Indian populations — including intravenous drug users, and commercial sex workers and their clients — from Avahan, the India AIDS initiative of the **Bill & Melinda Gates Foundation**. Pathfinder will work in the most densely populated areas of Maharashtra — where an estimated 96 percent of HIV infections occur through sexual transmission — to reach groups who are at greatest risk for acquiring and transmitting HIV infections.

The Office of the **United Nations High Commissioner for Refugees** (UNHCR) has become the 10th co-sponsor of the **Joint United Nations Program on AIDS (UNAIDS)**. They will focus on expanding and strengthening UNAIDS' efforts to combat HIV/AIDS among refugees, who are exposed to poverty, family disintegration, social disruption and increased sexual violence because of wars and conflict. UNHCR's strategic plan on AIDS and refugees will cover 7 million people in 120 countries worldwide, with the aim of scaling up comprehensive HIV testing and counseling programs, and preventing mother-to-child HIV transmission among refugee populations. **High Commissioner for Refugees Ruud Lubbers** said that refugees often are neglected in host countries' HIV/AIDS programs, and that including them in policies and interventions — including the provision of antiretroviral therapy — is vital to the success of any national strategy.



©Robert Gringle

Zimbabweans sell their fresh produce at a dusty rural crossroads. Community support is an important part of Zimbabwean life, in everything from selling harvested food to the health and well-being of community members.

The Life of a Depot Holder: A Few Words Speak Volumes

STORY AND PHOTOS BY ROBERT GRINGLE
MANAGEMENT SCIENCES FOR HEALTH

Forward believes he is now well-prepared to relay a wide range of interconnected information on reproductive and sexual health to those who live in his village.

Forward Kache greets us on the dusty road at the bottom of the hill by his home in Bindura, a rural area of Zimbabwe north of Harare known for the excellence of the tomatoes grown in the gardens that dot the countryside. He leads us up the steep, winding path to his home, which looks out over much of the rest of his village. As we settle into our designated places to sit with Forward, he politely answers our initial questions: He is 26 years old, as is his wife. They have two children, ages seven and 16. His wife and children are elsewhere at the moment so that Forward can give us his full attention.

"One child is 16-months-old?" we ask.

"No. My son is 16-years-old," Forward states.

We must look puzzled as we consider the idea of Forward as a father at 10 years of age. Was he actually sexually active at such an early age? And what about his wife?

A sad smile crosses Forward's face as he clarifies. His two children were born to his brother and his brother's wife, who both died shortly after the birth of their second child. From that time on, Forward and his wife have taken on the responsibilities of parents.

Two years ago, Forward accepted another responsibility that extends well beyond his immediate family. He agreed to become a depot holder, working with a Zimbabwe National Family Planning Council (ZNFPC) community-based distributor (CBD) to provide reproductive health and family planning services to underserved communities. Depot holders work out of their

homes to re-supply established CBD clients with family planning and reproductive health supplies, including birth control pills and condoms. This arrangement frees up CBDs to use more of their time to recruit new clients, and to follow up on former clients who have not continued using family planning methods.

Forward was selected to be a depot holder by his village, and he approaches his duties with considerable pride, great seriousness and care. He seems to be especially eager to talk to us about the *Expanded CBD Program* training offered through the Advance Africa Project. Funded by U.S. Agency for International Development, it has provided him, other depot holders and CBDs with additional skills so that they can offer information on sexually transmitted infections (STIs); make referrals to HIV/AIDS voluntary counseling and testing (VCT) sites; and provide access to services for the prevention of mother-to-child transmission (PMTCT) of HIV. Forward believes he is now well prepared to relay a wide range of interconnected information on reproductive and sexual health to those who live in his village. He emphasizes that he knows for a fact that HIV/AIDS can have devastating effects on men, women, adolescents and children within his community.

Although being faithful to one partner and practicing abstinence are both laudable ideals that Forward promotes when he talks to individuals and groups about the risks of becoming HIV-positive, he also makes sure clients understand that the proper use of condom barrier methods of contraception can help prevent the transmission of HIV and STIs. Forward unlocks a large rectangular chest to show us the contraceptives and condoms he makes available to those in his village who are receiving services through the *Expanded CBD Program*. He has both male and female condoms that he can distribute. He gives out about 400 condoms per month — mostly male condoms, although female condoms are also in demand.

Before Forward first accepted responsibilities as a depot holder, he wanted to make sure his wife understood the impact his position would have on their lives. Women would be coming to their house to talk about family planning methods, to receive birth control pills, and to seek information on the highly personal matters of sex, HIV/AIDS and STIs. Likewise, men would also be seeking out Forward for similar information and to procure condoms.

Forward tells us that his wife decided to set aside her reservations in order to support her husband in his new role. After two years of experiences, she now takes pride in the service her husband provides, and frequently tells her friends that by being supportive she can also show how much she trusts her husband to be faithful. She also says how proud she is of the good example he presents to their children and the other people in the village.

Forward feels that his help often extends beyond re-supplying family planning methods and providing information on how to stop the spread of HIV/AIDS and STIs. He illustrates this point with a story that is, in his words, "not yet over."

An adult woman in the village came to ask Forward how she could receive VCT services to determine if she was HIV-positive. Forward provided her with referral information, and she promised she would follow through on testing. A few weeks passed, and the woman came to visit Forward again. She had been tested. She was HIV-positive.

The woman told Forward that, based on the information he had given her, she was not surprised by her HIV status. She knew that her personal actions and sexual activity had placed her at high risk. At first, she told no one else of her test results. Then she started telling those people whom she knew were receiving family planning and reproductive health information and supplies from Forward. She reasoned that they would be well informed about HIV/AIDS, and therefore would be more understanding of her condition.

Forward told us that he was especially proud of how his clients reacted when their neighbor shared her HIV status. Most of them made a point of showing their support by sharing food with her, and working next to her in the gardens.

However, the woman's health has begun to decline. At one point, she had to meet Forward at the bottom of the hill to his house. She confided that constant diarrhea was leaving her too weak to climb hills. Forward was able to provide her with information on nutrition, and instructions for ingredients she could mix together and take to better control diarrhea. By the next week, the woman was strong enough to walk up the hill and thank Forward for his help. Now, Forward gauges the woman's health by whether or not she can come visit him at his home.

The day before our visit, Forward had seen the woman walking along the road, and she had said she didn't know how much longer she would be able to make the climb to his house — even on her 'good' days. She knows that the whole community will soon know she has a serious illness. She suspects that old rumors about her are circulating again. Nonetheless, she is comforted by knowing there are those who will not judge her too harshly, and some others who will recognize that they also face the risk of HIV infection, because of their own behavior or the behavior of their spouses and other sex partners.

Forward pauses in his story and, when he continues, he appears to have changed the subject. "My wife is very pregnant," he says, "And is close to birth — within this month she will deliver."

We congratulate him on the upcoming birth of his first child. Forward accepts our best wishes, but gently and firmly corrects us. This will be their third child, he informs us — the first from the union between himself and his wife — but this child will have the



©Robert Gringle

'Depot holder' Forward Kache integrates family planning and HIV prevention efforts in his community in rural Bindura, Zimbabwe.

advantages of growing up with two older brothers.

There is another pause, and Forward appears to be reflecting on the words he has chosen to correct us. "Maybe you should also know something else," he says. "You see, my commitment to being a depot holder goes beyond village honor and service."

Forward stares out the door of his house, looking out over the hills and the other houses and dry gardens of his village. "You see," he repeats softly, "I have my first two children because my brother and his wife both died of AIDS."

Forward returns his focus to us, sitting in his house, and he looks at each of us in turn. "We must stop this from happening in our communities, and I must do my part," he states.

We nod in response, but are collectively otherwise speechless. Shortly after, we leave Forward's home, thanking him profusely for sharing his time, thoughts and hospitality.

On the road returning to Harare, we begin discussing what we have learned from our visit. In the coming days, we travel to other rural districts and interview other men and women working out of their homes as depot holders. Their stories vary, but they have in common with Forward a devotion to the *Expanded CBD Program* model, the family planning and reproductive health services they provide, and a pride in the training that has given them the ability to speak knowledgeably about HIV infection and STIs, VCT referrals, and treatment that can prevent the transmission of HIV to newborn children.

Our collective observations gradually take shape as a single consensus: The personal experiences of Forward Kache and other depot holders who work with CBDs succinctly sum up volumes of written facts and professional analyses on how this well-intentioned program concept works in practice, providing for healthier families within communities, and offering tangibly linked services for stemming the tide of the HIV/AIDS pandemic. We also agree on the single most important unanswered question: What would be needed for the *Expanded CBD Program* to be implemented throughout Zimbabwe, for the greater good of all?

For more information, please visit www.advanceafrica.org

'You see,' he repeats softly, 'I have my first two children because my brother and his wife both died of AIDS.'

— Forward Kache

Integrating Family Planning and PMTCT Services

BY NAOMI RUTENBERG, PH.D., DEPUTY DIRECTOR
& CAROLYN BAEK, MSc, STAFF PROGRAM ASSOCIATE

HORIZONS PROGRAM

Preventing unintended pregnancies among HIV-positive women through family planning services is one of the four cornerstones of a comprehensive program for prevention of mother-to-child HIV transmission. Effective family planning services for HIV-positive women can help reduce the number of children potentially orphaned when parents die of AIDS-related illnesses. They can also lessen the vulnerability of HIV-positive women to morbidity and mortality related to pregnancy and lactation, and safeguard their health by enabling them to space births.

To better understand how well family planning information and services are integrated into prevention of mother-to-child transmission (PMTCT) initiatives in resource-poor settings, the Population Council conducted a rapid review of current programs in developing countries. Work on this topic by the Population Council has been supported by World Health Organization, UNAIDS, UNICEF and the U.S. Agency for International Development. The review included an analysis of data from recent operations research studies conducted by Horizons and PMTCT program evaluations. It also included interviews with international program managers, and site visits and interviews with PMTCT site managers and providers in Kenya, Uganda, the Dominican Republic, India and Thailand. The review looked at policies, training, communications, demand for family planning among PMTCT clients, how family planning services are organized for women receiving PMTCT services and how PMTCT clients use family planning.

Meeting the Family Planning Needs of Positive Women

In settings such as Uganda and Kenya, where HIV prevalence is high and contraceptive use is low, most PMTCT services offer little more than family planning counseling as part of antenatal care. The impact of this counseling is limited because women have more immediate concerns about pregnancy, delivery and care of the newborn, and HIV-positive women are also preoccupied with coping that they are infected. Family planning services, where providers may not even be aware of clients' HIV status, generally provide postnatal follow-up, particularly in high-prevalence settings.

Faith-based organizations are important implementers of PMTCT services in Africa, but offer limited family planning services at best and, sometimes, none at all. Faith-based organizations that do offer family planning services often ask that clients come only as couples, or only offer counseling on natural methods; some also limit their involvement to providing referrals. For example, sites in Rwanda supported by Catholic organizations are some of the most effective in the region in offering such PMTCT services like HIV counseling and testing, short course antiretroviral treatment and infant feeding counseling. However, the services at these sites do not include comprehensive family planning counseling and provision of contraceptives.

Programs place a stronger emphasis on family planning within PMTCT where postpartum contraception — such as tubal ligation — is widely accepted by clients and providers. For example, PMTCT programs in the Dominican Republic and Thailand have targeted family planning components within their PMTCT services, and sterilization is strongly recommended to HIV-positive women. The much lower volume of HIV-positive clients in these countries allows providers to devote a team to PMTCT. Additionally, these programs have greater resources to offer caesarean sections with concurrent tubal ligation.

PMTCT Helps with Childbearing Decisions

HIV-positive women both want to achieve family size norms for their communities and to have HIV-negative children. Providers report that most HIV-positive women want to have at least one or two children to carry on the family name, cement the marriage, avoid stigma brought by going against community norms about childbearing, and provide companionship for their children. According to one provider in India, "a lot of [PMTCT clients] say that if there are two children, at least after their parents' death[s], the siblings will be together and not alone." Yet many HIV-positive women also have witnessed that some children born to HIV-positive mothers in their communities fail to thrive or become orphaned, and they have fears about the negative impact on their own health if they become pregnant. For example, more than 85 percent of women at PMTCT sites in Kenya felt HIV-positive women should not get pregnant because their children will be infected and die, the pregnancy will adversely affect the health of the mother, and children will become orphaned.

On the other hand, PMTCT programs give hope for having healthy children. According to one provider in Uganda, "Previously they used to fear producing, because they knew it would lower their immunity and the child may be infected. But now with PMTCT awareness, that fear is gone. They now know there is a way of preventing mother-to-child transmission."

Another provider in Kenya said that PMTCT counseling also influences women not to have children: "Most pregnant mothers who come to the clinic and get to know they are HIV-positive opt not to have another child after receiving adequate counseling."

Contraceptive and Condom Use

In Kenya and Zambia, HIV-positive and negative people use contraceptives at similar levels. This suggests that factors such as local norms about fertility control and the acceptability of contraception play a greater role than one's HIV status in determining contraceptive use. However, HIV-positive women in these settings are more likely to use condoms than HIV-negative women.

In contrast, in the Dominican Republic — where HIV prevalence is low and use of permanent contraceptive methods is high — all HIV-positive women are offered tubal ligation either after elective caesarean section or vaginal delivery. Of the approximately 115 HIV-positive women who deliver annually in one Santo Domingo hospital, 99 percent choose sterilization either immediately after giving birth or 10 days postpartum. A PMTCT program manager at a second hospital in the city reported that condoms from the PMTCT program are used primarily for HIV prevention, because almost all of the HIV-positive women have undergone sterilization.

According to a study of 1,764 HIV-positive women from 37 hospital sites in Thailand completed by Lallemand et al in 2003, researchers found that the overall prevalence of sterilization at six weeks postpartum was 56 percent, while 92 percent of women indicated they were using some form of contraception. While sterilization is the second most common contraceptive method in Thailand — a quarter of currently married women have been sterilized — more HIV-positive women have undergone sterilization than HIV-negative women.

Providers in India also reported that sterilization is the most common contraceptive method in the country, and that sterilization is most popular among HIV-positive women. Indian providers strongly recommend that women who opt for steriliza-

'Most pregnant mothers who come to the clinic and get to know they are HIV-positive opt not to have another child after receiving adequate counseling.'

— Kenyan Health Provider

tion use condoms, as well.

An important finding from the review is that HIV-positive women increasingly have positive attitudes about condoms and are using them more often. HIV-positive women view condoms as good for their health, providing protection from re-infection and other STIs that may compromise their health, as well as from unwanted pregnancy. Condoms, unlike other methods, are also perceived as available and cheap, even if they have to be purchased. The major obstacle is getting male partners to agree to use them.

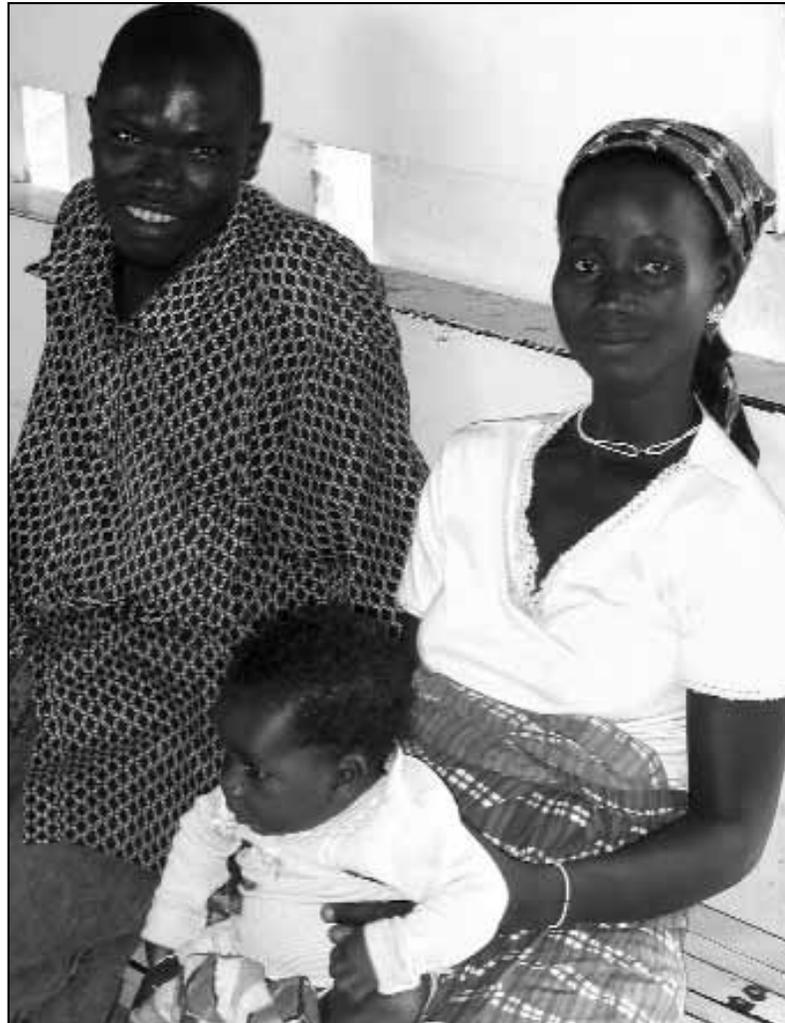
Improving Integration

The review concluded that PMTCT programs will be more successful in promoting effective contraceptive use among their clients if the family planning counseling and services are integrated, rather than offered as a parallel service. Family planning counseling for HIV-positive women must be sensitive to their needs, including their right to make an informed decision about having another child and their desire to involve male partners. The emphasis would vary, depending on the setting, but family planning counseling should help HIV-positive women introduce condoms to their partners, and/or support for adoption of sterilization.

Partner support will enhance the effectiveness of a number of components of PMTCT programs. PMTCT programs thus need to continue to involve men, provide them with information, and encourage them to get tested for HIV. Counseling HIV-positive women on condom use should go beyond the advantages, disadvantages and mechanics of use. Instead, it should also address whether and how a woman can disclose her HIV status, and how to encourage her partner to get an HIV test. PMTCT programs should also offer female condoms and counseling, as well as supplies of emergency contraception as a back-up for condoms, to enhance their effectiveness.

In many settings, a large proportion of women do not return for postnatal follow-up. Putting more emphasis on family planning counseling for HIV-positive women, and ensuring that women have made a decision about a contraceptive method in the antenatal period, would reduce the need to re-establish contact after delivery. Postnatal family planning support targeted to the needs of HIV-positive women can be offered by PMTCT program staff, peer counselors or friends. The M2M2B project in South Africa provides peer support for HIV-positive women identified in prenatal care, including the selection and follow-up of a family planning method. Uganda is piloting a postnatal peer support program with the objective of increasing family planning use among HIV-positive women. Health systems should also develop mechanisms for confidentially informing family planning providers about a client's HIV status in order to ensure a continuum of care. Finally, all PMTCT-Plus programs — which provide treatment to women found during pregnancy to be HIV-positive — should offer family planning.

Awareness of the need to emphasize family planning within PMTCT programs at many different levels is growing. An impor-



©Melissa May

A young couple and their infant wait to see a nurse in Kpassa, Ghana. In the Kpassa Health Center there are no doctors, only nurses.

tant recent initiative is the **Gilon Call to Action** (*see page 9*), based on a consultation by UN agencies with a wide range of stakeholders to identify opportunities for strengthening potential synergies between reproductive health and HIV/AIDS efforts. The **Gilon Call to Action** focuses on the linkage between family planning and PMTCT, and outlines recommended actions for policy and advocacy, program development, resource mobilization and monitoring, evaluation and research.

For more information about this research, contact Naomi Rutenberg at nrutenberg@pcdc.org or Carolyn Baek at cbaek@pcdc.org.

The Horizons Program, funded by the U.S. Agency for International Development, is an HIV/AIDS operations research project implemented by the Population Council in partnership with the International Center for Research on Women, the Program for Appropriate Technology in Health, the International HIV/AIDS Alliance, Tulane University, Family Health International and Johns Hopkins University. Any opinions expressed are those of the authors and do not necessarily reflect the views of USAID. The Horizons Project is located at 4301 Connecticut Ave., NW, Suite 280, Washington, D.C. 20008; 202-237-9400, horizons@pcdc.org. Visit the Horizons page on the Population Council website: www.popcouncil.org/horizons.



Dr. Nils Daulaire
Global Health Council

Letter from
the President

Integrating Lessons Learned from Family Planning

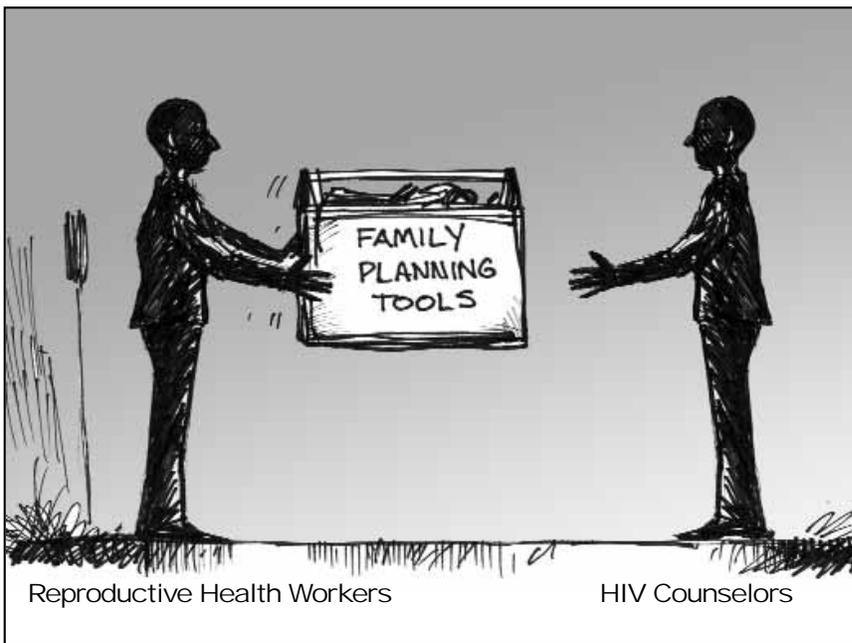
Worldwide, well over 80 percent of new HIV infections are the result of sex between men and women. The principal strategies for slowing the spread of AIDS are therefore aimed at modifying sexual behavior, and providing physical barriers against the person-to-person transmission of the virus.

For four decades, family planning and reproductive health programs around the world have worked at addressing these same challenges, both to prevent unintended pregnancies and to reduce the spread of sexually transmitted infections. From bench research to operations research to service delivery, these efforts have been among the most successful and effective interventions ever undertaken at the global level. The result has been the spread of family planning services in a wide range of forms to virtually every corner of the developing world, and a dramatic reduction in family size and population growth rates in many countries.

The Cairo International Conference on Population and Development, which took place exactly a decade ago, was a watershed event in refocusing the global community's attention in the family planning arena. From the earlier principal emphasis on driving down population growth rates, the Cairo agenda established the vital importance of serving the needs of individuals, especially women who bear the physical brunt of fertility. In country after country over the course of the ensuing decade, demographic targets have been progressively replaced with client-centered approaches. Quality has begun to nudge quantity as a key marker of program effectiveness.

As this issue of *Global AIDSlink* makes clear, there is a great deal of overlap between today's family planning and reproductive health services and those aimed at reducing the spread and impact of AIDS, and there is much to be learned that would greatly enhance AIDS control efforts. Well-assessed communications aimed at modifying sexual norms and behaviors, high quality services that meet the needs of clients, tools for measuring

ence in addressing the systemic challenges of development; some are advocates with limited background in program implementation. The experience, tools and expertise developed over decades in family planning programs, through painstaking trial-and-error, should provide valuable insights that could enormously accelerate progress in the most urgent global health undertaking in history.



the effectiveness of outreach to underserved populations, logistics and management operations for commodities and drugs, and the training and continued support of key service delivery personnel at the periphery: these are at the heart of today's AIDS efforts, and in many places their foundation is the work that has been carried out for years in family planning.

The global effort to control AIDS has brought a whole new set of actors into the global health arena. Some of them come from the social services side and are new to the health sector; some come from northern institutions with little experi-

Ultimately, a thoughtful and strategic approach to AIDS should intrinsically strengthen health and social support systems. Not only will this have an impact on AIDS, it should result in better reproductive health programs for women and young couples, improve essential services for children, and make health infrastructures — both physical and human — more robust and capable.

It is our common responsibility to make sure that these synergies are realized.

The Glion Call to Action on Family Planning and HIV/AIDS in Women and Children

The linkages between reproductive health and HIV/AIDS prevention and care must be strengthened in order to achieve internationally agreed development goals. United Nations agencies have initiated a series of

consultations to identify ways to build and reinforce these linkages. The Glion Call to Action reflects the consensus of the first consultation in May 2004, which focused on the linkage between family planning and

prevention of mother-to-child HIV transmission. The call is set within the context of the objectives and actions agreed at the 1994 Cairo International Conference on Population and Development (ICPD).

PREAMBLE

In order to achieve internationally agreed development goals, it is vital that the linkages between reproductive health (RH) and HIV/AIDS prevention and care be addressed. To date the benefits of the linkages have not been fully realized. UN agencies have initiated consultations with a wide range of stakeholders to identify opportunities for strengthening potential synergies between reproductive health and HIV/AIDS efforts. This document reflects the consensus of one such consultation, which focused on the linkage between family planning (a key component of RH) and prevention of mother-to-child HIV transmission (PMTCT) (a key component of HIV/AIDS programmes).

The focus of the Glion Call to Action on preventing HIV among women and children is fully consistent with the parallel need for increased commitment to the health and well-being of women themselves. Therefore, the Glion Call to Action rests on the consensus achieved at the International Conference on Population and Development (ICPD) in Cairo and acknowledges the rights of women to decide freely on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence, and improving access to services so that couples and individuals can decide freely the number, spacing and timing of their children. In order to ensure that these rights are respected, policies, programmes and interventions must promote gender equality, and give priority to the poor and underserved populations.

RECOMMENDATIONS FOR ACTION

We, the undersigned, call upon governments, parliamentarians, UN agencies, donors, civil society, including NGOs and community-based organisations, to:

1. Policy and Advocacy

- a. Increase awareness, understanding and commitment to the four elements of PMTCT.
- b. Commit to developing and implementing policies that strengthen the linkage between family planning and PMTCT.
- c. Formulate legislation and policies that support the rights of all women, including HIV-infected women, to make informed choices about their reproductive lives.

2. Programme Development

- a. Strengthen commitment to achieving universal access to reproductive health services, including family planning, and recognize and support the contribution of these services to HIV/AIDS prevention efforts.
- b. Ensure access for all women to family planning information and services, within both PMTCT and voluntary counselling and testing (VCT) services.
- c. Ensure that psycho-social counselling and support services are available to women seeking to be tested for HIV and for women infected with HIV.
- d. Operationalise the linkage between family planning and PMTCT (through training, ensuring the supply of ARVs, contraceptives, HIV testing kits, pregnancy testing kits, male and female condoms, and establishing referral systems and tracking mechanisms)
- e. Promote the concept of dual protection against transmission of HIV and other STIs as well as unintended pregnancy by the use of condoms alone or in combination with other methods of contraception.
- f. Ensure that condoms are available and distributed at family planning, PMTCT and VCT settings, together with the information and counselling necessary for their correct and consistent use.

A Broader Approach to PMTCT

- ♦ Although the prevention of MTCT is often restricted to the provision of anti-retrovirals (ARV) to pregnant women who are infected with HIV, as well as safe delivery practices and infant feeding counselling and support, a broader approach has been defined by the UN and includes the following four elements:
 1. Preventing primary HIV infection in women;
 2. Preventing unintended pregnancies in women with HIV infection;
 3. Preventing transmission from HIV-infected pregnant women to their infants; and
 4. Providing care, treatment and support for HIV-infected women identified through pMTCT or VCT programs and their families.
- ♦ *All four elements* are essential if the UN goal for reducing the proportion of infants infected with HIV by 20 percent by 2005 and 50 percent by 2010 is to be attained.
- ♦ Current estimates show that, because of limitations in coverage, use of services and drug efficacy, using the third element alone will only reduce HIV in infants by between 2 percent and 12 percent in many countries.
- ♦ The most effective way to reduce the proportion of infants infected by HIV is by preventing primary HIV infection in women (element 1), and by preventing unintended pregnancy among women infected by HIV (element 2). These two measures have intrinsic benefits to women and can decrease the proportion of infants infected by HIV by 35 percent to 45 percent in some countries with a significant contribution coming from the provision of family planning information, services and counselling.

- g. Promote and facilitate the participation of men, both as individuals and as a partner in a relationship, in PMTCT programmes.

- h. Ensure the participation of young people in the design of programmes addressing their special needs in the prevention of MTCT.

3. Resource Mobilisation

- a. Allocate the necessary funds for the implementation of all four elements of PMTCT, including family planning.
- b. Improve cooperation and coordination among donors to support and strengthen the linkage.
- c. Rectify the severe funding shortfall for the provision of RH supplies, including contraceptives and condoms, and invest in the logistics systems in countries to improve their ability to procure, forecast and deliver those supplies.

4. Monitoring and Evaluation and Research

- a. Build on existing data to develop and improve monitoring and evaluation mechanisms for programmes linking family planning to PMTCT services, including measurement of the reduction of numbers of women and infants infected with HIV.
- b. Continue innovative operations research to identify the most effective and efficient strategies and technologies to support linkages between PMTCT and family planning programs.

For further information, contact www.unfpa.org

Strengthening Dual Protection for High-Risk Filipino Youth

BY LINDA BRUCE, SENIOR PROGRAM OFFICER

PROGRAM FOR APPROPRIATE TECHNOLOGY IN HEALTH

In an effort to improve contraceptive use among youth engaging in high-risk behaviors, PRIME II built on a successful sexually transmitted infection (STI)/HIV prevention project in the Philippines, by working through non-traditional providers. As a result, youth exposed to the program intervention were significantly more likely than their 2002 cohorts to use modern contraceptive methods (i.e. the pill), as well as the dual protection provided by condoms plus an additional contraceptive during high-risk behaviors.

Studies indicate that youth (aged 10-to-24) who engage in high-risk sexual behaviors are at great risk of unwanted pregnancies and STIs, including HIV and AIDS. This is due to low awareness of reproductive health issues, risky sexual behaviors (early sexual debut, multiple partners, unprotected sex, etc.) and adolescents' (aged 10-to-19) limited access to preventive and educational services at government clinics. This is particularly true in the Philippines, where a former government mandate forbidding the provision of reproductive health services to unmarried couples under age 18 has resulted in a dearth of traditional health services that are available to adolescents. Restricted access to contraceptive supplies and reproductive health services — compounded with the shame and guilt many feel from seeking them — have influenced the country's relatively high rates of adolescent pregnancy, abortion and STIs. There is a pressing need to reach youth, particularly in light of adolescents' unique informational needs, and the serious consequences of unprotected sex.

To this end, PRIME II partner Programs for Appropriate Technology in Health (PATH) sought to strengthen dual protection against unwanted pregnancy and STIs, including HIV, during outreach to high-risk adolescents in the Philippines. Through its AIDS Surveillance and Education Project (ASEP), PATH has worked for the past eight years to promote safer reproductive health behaviors among groups identified to be most at-risk of exposure to STIs and HIV. ASEP was carried out in cooperation with the Philippine Department of Health and the United States Agency for International Development (USAID)/Manila. The program targets urban high-risk groups, including commercial sex workers, their clients and adolescents who engage in risky sexual behaviors. As part of ASEP, PATH partnered with local nongovernmental organizations (NGOs) working on the front lines of HIV/AIDS prevention. These NGOs reach out to high-risk groups through community health outreach workers and peer educators that counsel target groups on risk and harm reduction, behavior change modification, STI and HIV/AIDS prevention, reproductive health and dual protection. Many partner NGOs also provide reproductive health care services.

PRIME II contributed a small amount of additional money to ASEP's highly successful, community-based STI/HIV education

and prevention program, to improve access to reproductive health/family planning information, and counseling and services for youth engaging in high-risk sexual behaviors. In collaboration with PATH, PRIME II expanded outreach and education activities on dual protection to adolescent freelance sex workers aged 18 and under, as well as their partners — a very elusive high-risk group that is difficult to reach through mainstream mechanisms. Project activities took place in four ASEP sites: Angeles, Cebu, Iloilo and Zamboanga.

PROJECT ACTIVITIES

The project sought to strengthen the community health outreach workers' capacity to effectively counsel youth on dual protection and, in particular, family planning. The workers' performance in outreach and counseling was sometimes inconsistent across sites; some, especially the experienced outreach workers, were able to provide more information than others.



Photo courtesy of PATH Foundation Philippines, Inc
Community health worker counseling at-risk youth in the Philippines.

Community health outreach workers received refresher trainings on dual protection, family planning methods and youth informational needs. In addition, a job aid was developed for them to use during their sessions to help ensure consistent information was being provided to the target audience, and to clarify job expectations. Entitled "Counseling on Dual Protection: STI/HIV and Pregnancy Prevention," the job aid includes action-oriented tips on effective communication skills, and messages on harm reduction, STI/HIV prevention, condom negotiation and pregnancy prevention. The outreach workers were so satisfied with the job aid that they asked for it to be translated and distributed to peer educators, who are often the first point of contact with the target audience.

In order to reinforce behavior change within the target audience, partner NGOs developed two youth-oriented,

pocket-size packets of information materials: one for female adolescent sex workers, and one for the adolescent clients and partners of sex workers. Messages focused on partner reduction, correct and consistent use of condoms, contraceptive methods used for pregnancy prevention and the importance of dual protection.

Community health outreach workers began expanding outreach where adolescent sex workers congregated, or at "pick-up points" and cruising areas, into their routine outreach activities. They counseled youth on dual protection, contraception and STI prevention and treatment; distributed the informational education materials; and referred the girls to government and NGO-run clinics and health centers for treatment and contraception.

RESULTS

The impact of the PRIME II activities were assessed by comparing the results of ASEP's 2002 Behavioral Monitoring Survey (BMS) with a similar one conducted in May 2003. The 2003 BMS focused on sentinel groups of interest to the PRIME II

With a limited amount of financial support, dual protection can be strengthened within existing HIV prevention programs.

project, namely young female sex workers (18 years and under) and potential male partners. Six partner NGOs in the four PRIME II project sites interviewed a total of 441 young female sex workers and 578 potential male partners in the red-light district from May to June 2003. The BMS looked at condom use, contraceptive use and STI care-seeking indicators among the survey respondents.

Condom Use

The overall percentage for condom use among young female sex workers during their last sexual intercourse increased from 60 percent in 2002 to 64.4 percent in 2003. The number of potential male partners using condoms also increased, with 48.4 percent reporting condom use during their last intercourse in 2003, compared to 45 percent in 2002.

Contraception

In 2003, 72.8 percent of young female sex workers reported using a method to prevent pregnancy, a number significantly higher than the 62 percent reported by their cohorts in 2002.

As in 2002, results for the 2003 study show that condoms are the most frequently mentioned contraceptive method among young female sex workers who took some contraceptive action. However, there was a significant increase in use of modern methods like the contraceptive pill among young female sex workers, with 9.1 percent using them in 2003, compared to only 6.7 percent in 2002. Use of condoms in addition to another modern contraceptive rose from 6.4 percent in 2002 to 9.4 percent in 2003. These numbers are promising indications that dual protection messages have been reaching the target audience. Reported use of non-modern methods (i.e. withdrawal, medicinal potions, etc.) declined substantially during the same time period, from 15.7 percent in 2002 to 9.7 percent in 2003).

STI Care Seeking

Data from the 2003 BMS indicate a significantly larger number of young female sex workers reporting symptoms of STIs, such as painful urination or discharge. The rise in these reports, from 20.3 percent in 2002 to 33 percent in 2003, shows an increased awareness of STI symptoms. Of those who reported having symptoms, 68.8 percent of the young female sex workers sought appropriate treatment for their symptoms, compared to the 55.4 percent who did in 2002.

Potential male partners did not report more STI symptoms or appropriate treatment in 2003 compared to the 2002 BMS, perhaps because male clients may be more elusive, transient and less interested in seeking care for STIs in established centers.

Factors Associated with Improved Outcomes

In a model that included exposure to the ASEP intervention, and numerous knowledge and belief variables among the two sentinel groups, "exposure to the intervention" and the "last partner being a customer" were significantly associated with increased condom use, increased use of modern contraception and improved STI care seeking. "Always prepared with a condom" was significantly associated with condom use while knowledge that it is possible to get pregnant with withdrawal is strongly associated with increased contraceptive use.

DISCUSSION AND LESSONS LEARNED

The results of the project indicate that outreach to youth can have an impact on reproductive health behaviors among this high-risk and often neglected group. With a limited amount of financial support, dual protection can be strengthened within existing HIV prevention programs. This project offers the following lessons learned for strengthening family planning within

Supporting Primary Providers in Integration

BY CHRISTOPHER KIGONGO & EMILY EVENS, INTRAHEALTH

In addition to PRIME II's work in the Philippines, IntraHealth has used its 25 years of experience to address the HIV/AIDS pandemic by integrating family planning services with efforts to prevent sexually transmitted infections (STIs), including HIV/AIDS. PRIME II has implemented 35 integrated programs in 18 countries throughout Africa, Asia, Eastern Europe and Latin America, each with the goal of strengthening the capacity of primary RH health care workers to provide both family planning and HIV prevention services.

Integration of FP and HIV prevention services improves health system efficiency, and helps reduce missed opportunities for care. Within health systems that rely on vertical programming, both family planning and STI/HIV prevention counseling needs are often neglected by primary providers. PRIME II advocates for dual protection counseling to protect against unwanted pregnancy, as well as STIs like HIV/AIDS. PRIME II has worked to remove obstacles to the provision of dual method counseling, including limited provider knowledge and skills, a dearth of reproductive health standards that promote using dual methods, and a lack of job expectations for providers that include these elements of care.

Integration of family planning and STI/HIV services is an efficient use of existing health systems. While there has been considerable investment in the FP service infrastructure over the past 25 years, the systems needed to provide HIV/AIDS prevention and treatment services are still developing. Although specialized equipment and facilities are needed for both types of services, much can be shared between the two. Trained laboratory technicians and departments, commodity distribution systems and health counselors are needed both by family planning and HIV prevention services, and FP programs supported the establishment of such infrastructure. Integration uses limited resources efficiently in resource-constrained settings.

Other factors supporting the integration of services include: limited provider time to update knowledge and skills; stagnating resources available for family planning amidst increasing resources for HIV/AIDS; the urgent need to provide HIV/AIDS prevention and care services; and the recognition that family planning can prevent vertical transmission of HIV. These factors contribute to the institutional enthusiasm to incorporate FP and HIV in primary health care.

Results of PRIME II's FP/HIV integration efforts are encouraging. In India's Uttar Pradesh state, PRIME II trained auxiliary nurse midwives and their supervisors, known as lady health visitors, to screen for STIs and counsel on HIV/AIDS prevention during family planning visits. After training, the providers were supported with job aids, clear performance expectations and supportive supervision to ensure they would perform according to standards. On-site follow-up observations revealed that the midwives scored 85 percent in family planning counseling skills, compared to just 30 percent before training. Ninety percent of lady health visitors provided supportive supervision to the auxiliary nurse midwives and, of those who received follow-up visits from their supervisors, 80 percent met state performance standards.

In Benin, PRIME II helped the Ministry of Health to create national reproductive health protocols that emphasize

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Challenging Cambodian Sexual Norms



BY JENNIFER HYMAN
MANAGING EDITOR, *GLOBAL AIDSLINK*

Cambodia — and police are among their primary clientele — no one will listen to them if they report the rapes.

‘The vast majority of men here lose their virginity to sex workers, and it affects the way that they view relations with women.’

— Luke Bearup

‘Many guys think I’m crazy, because I’m 23-years-old, and refuse to lose my virginity to a sex worker,’ my waiter explained to me, as I interviewed him after dinner. “But the really crazy guys are the ones who are willing to engage in *bauk*, and don’t feel bad because they can get away with it.”

In fact, the knowledge that few victims of Cambodia’s prevalent *bauk* — or gang rape — phenomenon ever dare talk about it has bred a feeling of impunity among its perpetrators.

Although the Khmer word *bauk* traditionally refers to the plus sign (+) used in mathematics, some young Cambodian men would translate the word to mean ‘added value’. And to women,

While some link the emergence of *bauk* with the closure of Cambodian brothels and karaoke bars in 2001, which forced most CSWs to move to the streets, sex workers are not its sole victims. Any young woman perceived to be breaking the country’s conservative sexual and social norms is also a target, and even less likely than the CSWs to speak out, or fight against the practice. Some young men also organize and participate in gang rapes against girlfriends they perceive as pressuring them into marriage or commitment, an unconventionally brutal means of breaking things off.

In this atmosphere of silence and shame, although it is hard to know the exact statistics of how many women contract sexually transmitted infections like HIV or have unintended pregnancies from *bauk*, there is no doubt about the acute intrinsic risks. Cambodia has the highest adult HIV-prevalence rate in Asia, at 2.6 percent of its population of 11.4 million (albeit down from 4 percent two years ago), and the main route of transmission has long been bound to sex workers and their clients. But, increasingly, as is true elsewhere in the world, those at highest risk are the women married to the clients of CSWs, as well as their children. Violent, multiple rapes also greatly increase the chances of a woman’s delicate tissues tearing, making her even more prone to contracting a disease.

Cambodia is a country ravaged by poverty, and it still bears the visceral physical and psychological scars borne from the years of genocide and other atrocities committed by Pol Pot’s Khmer Rouge regime. With 42.8 percent of the population under age 15, society remains cleft in two by the power of a few against the powerlessness of the many; between the haves and have-nots. Although it is often viewed as a means of maximizing economic resources by paying for only one sex worker, many of *bauk*’s perpetrators hail from the middle- and upper-class echelons of society, and others are the sons of well placed parents. While *bauk* is acutely prevalent in the capital of Phnom Penh, it has become a regular occurrence all around the country.



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Outreach workers during a training at CARE’s *Playing Safe* recreation center

it describes a far more pernicious and looming threat. *Bauk* happens when one or two young men secure the services of a commercial sex worker (CSW), and then as many as a dozen youth hiding nearby ambush and gang rape her. If she refuses to submit, she most likely will be beaten as she is forced into sex. Although indirect and direct sex workers are rampant in

“The vast majority of men here lose their virginity to sex workers, and it affects the way that they view relations with women,” explained Luke Bearup, project advisor for the *Play Safe* project run by CARE Cambodia, in conjunction with the local non-governmental organization Gender and Development in

Cambodia. Bearup is spearheading initiatives to provide the young men demographically most prone towards engaging in *bauk* an education about reproductive health and human rights. After undergoing three days of counseling, some of the young men are then trained to become peer educators in their communities. So far, 110 have been trained.

"We have to make it cool, and we attract groups like teams of football players, by inviting them to our recreation center to sing karaoke and play games like ping pong," said Bearup. "But once there, our staff begins frank dialogues with the young men about reproductive health and rights." Bearup says the young men are extremely responsive to this unique opportunity to speak openly about sex and relationships with women, and he is devising a training curriculum he hopes will be replicated around the country.

For women, however, such as young garment factory workers, they need to learn sexual empowerment and safer sex negotiation skills.

"Most of the women who become garment workers have left their parents' homes and rural life for the very first time, and they have newfound personal and sexual freedom," notes Claire Christie, CARE Cambodia's reproductive and sexual health advisor.

Christie is the technical advisor for a large reproductive rights program called *Sewing for a Healthy Future* in 25 of Phnom Penh's approximately 250 garment factories. Each factory typically employs thousands of workers, 90 percent of whom are female. Although most of the women meet the legally required age of 18, many appear far younger, and almost all are sexually naïve. Away from their families, living with few rules in close proximity to young male workers, they are vulnerable to unsafe sexual encounters that can lead to unintended pregnancy, the acquisition of STIs like HIV/AIDS, and rape.

"A young man will promise his love with a token in order for sexual relations to ensue," Christie explains. "He never actually intends to marry her, and she can't negotiate condom use, because having them signifies that she's a 'bad girl.'" Christie says that after he inevitably breaks up with her following sex, she is now viewed as a 'used girl' by male peers, and often becomes more vulnerable to sexual advances and sexual violence. Then, although she is not a sex worker, her options become increasingly limited, and she will be more easily lured into indirect sexual services with young men that offer her trinkets.

Sewing for a Healthy Future uses numerous methods to educate women about their rights, and to help destigmatize the use of condoms for dual protection against STIs and pregnancy.

CARE Cambodia was able to initiate *Sewing for a Healthy Future* by applying a cost-benefit analysis in their appeals to the general managers and human resource directors of garment factories. "We explain that it will affect their productivity if they have workers infected with HIV, and that workers need a top-down holistic approach that will provide them with the necessary prevention messages," says Christie.

She is typically able to convince factories to join both because the program is free and, as Christie admits, "I don't take no for an answer." But, moreover, CARE works to promote the advantages of corporate social responsibility in the factories, and they work with the Garment Manufacturers Association in Cambodia to highlight to potential international business partners companies that are investing in the wellbeing of their workers.

All of the participating factory human resource directors are part of an advocacy group called "Strengthening Activities for Factory Education" (SAFE), and work with CARE to implement the International Labor Organization's HIV/AIDS workplace policies.

Sewing for a Healthy Future also promotes educational and behavior communications change programs with the garment workers,



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A reproductive health counselor at Phnom Penh's Archid Garment Factory explains condom use to peer educators

'He never actually intends to marry her, and she can't negotiate condoms, because having them signifies that she's a 'bad girl.'

— Claire Christie

training about 15 workers every three months to become peer educators. They learn about gender violence, condom negotiation skills and how to delay the onset of sex, and are then are required to speak to 10 other garment workers about the skills that they've learned.

In an effort to make learning about sexual and reproductive health fun, the project has set up youth libraries in the garment factories and, three times a month, factory workers are encouraged to participate in structured games about reproductive health and HIV/AIDS, which offer prizes such as soap, toothbrushes and condoms. The project also makes use of radio broadcast systems in the factories, to air programs that include questions and answers about sexual health, and songs about preventing sexually transmitted infections.

And, in conjunction with Population Services International, CARE's *Sewing for a Healthy Future* program is also offering socially marketed condoms and birth control pills.

"The girls love the program," remarks Christie, but she acknowledges that it's difficult to quantitatively measure behavior change. "Ultimately, young women working in garment factories now feel much better about carrying condoms, and they're much more open about talking about reproductive rights."

"Some of the attitudes we're trying to change run so deep, it won't work if you knock people over the head," notes Bearup, about the behavior change he is witnessing among the young men he works with. "Just as *bauk* often stems from peer pressure, we are trying to make our own movement of cool, where aligning human rights and gender awareness is considered socially-acceptable, modern behavior."

For more information, please visit www.playsafe.info or www.care.org

Training Integration

**MARK A. BARONE, DIRECTOR, HIV/STI PROGRAM
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THE ACQUIRE PROJECT, ENGENERHEALTH**

Integrating family planning programs with those centered on sexually transmitted infections (STIs) like HIV involves providing prevention and care services as part of a unified, coordinated strategy. Integrated services must address clients' risks for unintended pregnancy and HIV/STI transmission, as well as their need for pregnancy and HIV-related care and support. An integrated approach to counseling is often a key component of such synergized programs and services, and this more comprehensive, client-centered approach to counseling has become critically important in light of the growing HIV/AIDS pandemic. Not only do family planning clients need to understand their risks for HIV, and take these risks into account when making decisions about their sexual and reproductive health, but HIV-positive women have pregnancy prevention needs as well. Clients' needs relating to HIV and family planning (FP) are often inextricably linked; addressing sexuality is fundamental to both.

The client-centered approach to counseling places the specific needs, risks, concerns and circumstances of each client at the center of every counseling session. As a result, the interaction between the client and the provider can be a two-way dialogue that enables clients to:

- Understand and perceive their own risks of HIV/STI infection and unintended pregnancy;
- Explore options for protecting their health;
- Make decisions that are informed and realistic, based on their own needs and the social context in which they live; and
- Develop the skills to effectively carry out those decisions.

EngenderHealth developed *Integration of HIV/STI Prevention, Sexuality, and Dual Protection in Family Planning Counseling: A Training Manual* to help increase providers' comfort in addressing sensitive issues related to sexuality, gender and HIV/AIDS, and to clarify the values and overcome the biases necessary to do so. This two-volume set, consisting of a trainers' manual and handouts for participants, features participatory exercises on sexuality and gender; HIV/STI transmission, prevention and dual protection; integrated counseling skills; and other trainers' resources. It is designed primarily for training health care providers who offer counseling services, but the exercises can also be used with a wide range of individuals who work in sexual and reproductive health. This includes all levels of family planning staff; health outreach workers; HIV/STI educators, counselors and frontline staff; and members of community groups.

The two-volume manual contains a collection of training exercises that use participatory approaches such as brainstorming, role plays, small group work and case studies. The first volume is the training manual itself, which is divided into three sections. The first section, "Understanding Sexuality and Gender" helps participants explore and clarify their values and attitudes about sensitive issues related to sexuality and gender. It also increases their

knowledge of sexual anatomy, physiology, sexual responses and problems, psychosexual development and the life cycle, sexual orientation, and sexual health and rights, as well as information about gender roles and stereotypes. This first section is predicated on the belief that an understanding of and comfort with issues related to sexuality and gender are fundamental building blocks to addressing clients' sexual and reproductive health needs.



Photo courtesy of EngenderHealth

Nigerian practitioners learn about integrating HIV/STI prevention, sexuality and dual protection into family planning counseling, through a draft curriculum designed by EngenderHealth.

The second section, "Introduction to HIV/STI Prevention and Dual Protection" provides participants with basic information about HIV/STI prevention, safer sex and dual protection; and explores values, attitudes and biases related to HIV/STIs, people with HIV/AIDS and condoms. The third and final section, "Developing Integrated Counseling Skills," provides a framework for integrated, dual protection counseling. It also provides an opportunity for participants to practice a range of essential skills for integrating HIV/STI concerns, sexuality, dual protection and family planning counseling. The second volume includes handouts for participants.

Most of the exercises are designed to be carried out with groups of 10 to 30 participants. The manual is not intended to be followed exercise-by-exercise. Rather, it is designed to provide facilitators with exercises to select from and to create training workshops that reflect the needs of the particular participants they will be working with. Exercises can be used in different ways, and adapted locally for audiences from different cultures and with varied levels of background knowledge. In order to help facilitators develop such individualized workshops, the manual contains the following tools:

- A total of 59 training exercises with comprehensive instructions for facilitators;
- Sample one-to-five-day training agendas that feature different topics;
- Participant handouts and educational aids; and

- Suggestions and tips for facilitators on planning and conducting successful workshops

USING THE MANUAL IN NIGERIA

A workshop for training trainers on integrating HIV/STI prevention, sexuality and dual protection into family planning counseling was conducted in September, 2002, in Ibadan, Nigeria, using the working draft curriculum. Most of the 25 participants, from the states of Bauchi, Benue, Enugu, Oyo and Plateau, were nurses from federal health institutions, state ministries of health, local government health facilities, mission hospitals and private health institutions.

The five-day workshop covered both training technique and technical content issues such as basic training principles and techniques; steps of training; an overview of the curriculum; information on HIV/STI, dual protection and sexuality; and the concept of the new framework for integrated dual protection counseling.

Results from the pre- and post-test questionnaire showed a 60 percent increase in knowledge among the workshop participants about HIV/STI prevention, sexuality, dual protection, and the importance of integrating these into existing family planning counseling sessions. Nearly all of the participants reported that their attitudes and understanding of sexuality and sexual behaviors had changed during the workshop. Most felt they were now better equipped to discuss issues of HIV/STIs and sexuality with colleagues, and also with clients during counseling sessions. Participants said they particularly liked the rich content of the curriculum and the participatory nature of the workshop.

Throughout 2003, the trainers conducted a total of eight five-day integrated workshops on HIV/STI prevention, sexuality and dual protection counseling, using the working draft curriculum for providers in Nigerian health facilities from Enugu, Ibadan, Jos, Markurdi, Nsukka and Yemetu. Workshop participants were primarily nurse midwives who provide family planning, maternal child health and sexually transmitted infection services. These workshops aimed to improve the counseling skills of providers and increase their level of comfort in discussing sexuality.

OTHER INTEGRATION RESOURCES

Currently, the working draft curriculum is being adapted to focus specifically on dual protection — defined as any strategy for preventing both unintended pregnancy and the transmission of HIV/STIs. A trainer's manual and a participant's handbook, as well as a job aid for service providers to use during counseling sessions, are under development. These materials will be used as part of an operations research project being conducted by EngenderHealth and Family Health International, to test the integration of dual protection counseling into family planning clinics in Ethiopia

Additionally, many of the exercises from the working draft integration curriculum have been incorporated into EngenderHealth's *Comprehensive Counseling for Reproductive Health: An Integrated Curriculum*, designed to put the concept of integrated reproductive health services into practice by helping all levels of service providers develop the communication and counseling skills needed to assess and address their clients' comprehensive sexual and reproductive health needs. This curriculum was field tested in Bangladesh, Ghana and Kenya before being finalized.

Both curricula are available from EngenderHealth, 440 Ninth Avenue, New York, NY 10001 USA, 212-561-8000, hivaidinfo@engenderhealth.org. PDF versions can be downloaded from EngenderHealth's website: <http://engenderhealth.org/res/offc/hiv/integration/index.html> and the comprehensive counseling curriculum can be found at <http://www.engenderhealth.org/res/offc/counsel/ccrh/index.html>

Integrating FP and HIV/AIDS: Don't Forget the Supply Chain

Providing HIV/AIDS prevention and treatment at service delivery points that already offer family planning requires expanding service capacity, and increasing the quantity and range of medical commodities that are used. Integrated management is generally considered to be more efficient than parallel management in such cases, particularly since family planning is a critical component of HIV/AIDS programs and it employs some of the same products, like condoms. But, if existing logistics systems are weak or are not capable of handling more complex HIV/AIDS-related commodities, integrated management can compromise the availability of all products.

In many developing countries, a long history of population assistance has meant that the strongest logistics management systems for public health are associated with family planning programs. This can present an opportunity for improving access to new HIV/AIDS commodities by adapting well-built logistics systems. But there is no guarantee that new products can be successfully introduced into family planning logistics systems or that reproductive health commodities can be easily integrated into other systems. For example, when contraceptives were incorporated into essential drug management as part of health care reform in one West African nation, weaknesses in the existing system for essential drugs soon created repeated contraceptive shortages throughout the country where few had occurred before.

In its *2003 Guide on Family Planning/HIV Integration*, USAID specified that when systems are weak, the commodity needs of both programs should be a priority. They advised that the pros and cons of the existing commodity systems should be analyzed prior to full integration, in order to avoid shortages.

"Whether you're thinking about integrating HIV/AIDS and family planning, or any other types of health programs, the questions you need to ask are the same — what commodities are needed; where do they come from; how are they being managed; and what is the capacity to handle them?" says Claudia Allers, a public health logistics advisor with the DELIVER project. Allers notes that it may even be necessary to redesign a well-functioning logistics system if products like laboratory reagents, which have short shelf lives and special storage needs, are introduced for the first time. And in some cases, maintaining parallel systems until logistics management capacity can be ensured may actually be a better choice.

Integrating commodity management of family planning and HIV/AIDS programs should be incorporated into program planning and implementation strategies from the beginning. Ultimately, program managers need to employ the best type of management system to make products available to patients when and where they need them.

— Paul Crystal, DELIVER/JSI

Waking the Giant: Making the Case for Mainstreaming

By KEVIN OSBORNE, SENIOR ADVISOR: HIV/AIDS
INTERNATIONAL PLANNED PARENTHOOD FEDERATION

The importance of addressing HIV/AIDS from a stronger sexual and reproductive health and rights perspective has over the past few months been gaining increased global momentum and recognition. Earlier this year, the All Party Parliamentary Group on Population, Development and Reproductive Health in the UK commenced their hearings into the very question of integration: its successes, failures and contextual realities. The Glion Call to Action (*see page 8*) — released in June — specifically addressed the integration aspects involved in PMTCT programs and policies. And in May, UNFPA hosted a series of technical meetings that aimed to explore some of the broader technicalities of integration. This advocacy document was launched in July at the Bangkok XV International AIDS Conference.

Clearly, the question of when, where and how to integrate HIV/AIDS with reproductive health has been plaguing programmers and policy makers, donors and service providers. Answering these questions with meaningful action is not only long overdue but — in the age of increased awareness, and treatment access increasingly becoming a reality — it is unarguably the most unexplored terrain of our international response. For it is only with the concerted effort and coordinated involvement of the sexual and reproductive health community that the lofty Millennium Development Goals; the UN General Assembly's Special Session on HIV/AIDS Commitments; the '3 by 5' targets; and even new modalities of reducing HIV/AIDS-related stigma, will be achieved. The mainstreaming of HIV/AIDS is perhaps not only an untapped avenue, but it also has the potential to awake the full potential of a by-and-large underused resource. Getting there, however, would involve a change in mindset of all the role players involved. A 'business as usual' approach that does not move beyond rhetoric will have damning consequences. The exceptionality of HIV/AIDS as a largely sexually transmitted infection requires an exceptional response — especially from sexual and reproductive health providers.

When seen in the context of the long history of family planning and population programs, the question of how to integrate HIV/AIDS prevention, care and treatment services into sexual and reproductive health (SRH) policies, programs and practices is relatively new. But, considering the urgency of the AIDS epidemic, it is a question that needs to be addressed with a greater sense of clarity, consensus and purpose. Because of the dynamic nature of this epidemic and its regional variations, the very context within which integration issues need to be considered is ever-changing.

If the complex process of mainstreaming is to be effective and long-lasting, it has to take place at the personal, policy and program levels concurrently. Integration makes both good economic

and programmatic sense: From utilizing voluntary counseling and testing (VCT) as a pivotal entry point for both prevention and care in sexual health services, to addressing integrated prevention (including the prevention needs of the HIV-positive community); from the syndromatic management of other sexually transmitted infections, to meeting the maternal health needs of HIV-positive women. This much we now know. The challenge now is to apply this knowledge not only to what we do but, more importantly, how we do it — globally, regionally and at a national level.

All the individuals involved — program staff, service providers



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Young girls in the Dominican Republic learn through an integrated approach about family planning and preventing STIs/HIV.

and clients — must feel that they are contributing to the process of change. This sense of 'ownership' is a key step towards collective responsibility, as opposed to the traditional culture of separation. A commonly voiced fear is that the linking of family planning with HIV/AIDS prevention and care services (along with their associated stigma) will lower the acceptance and use of modern family planning methods by conventional clients. However, these prejudices can be overcome by training and guidance. In some places, indeed, the integration of HIV and other sexually transmitted infection prevention elements may actually have advanced family planning objectives, by lowering rates of infection. Integration thus means investing and believing in people who are already providing sexual health services; this is cost-effective and promotes programmatic synergy. Building the AIDS competencies of sexual and reproductive health service providers — from the shantytown favelas in Rio, to the townships of Soweto — will simultaneously begin to address in a clear and practical manner the global AIDS capacity gap.

From a policy perspective, two avenues need to be more fully explored. The first relates to the broad structural national environment in which integration processes occur, and the other

relates directly to the policies that flow from this environment. Without a clear understanding of how the one informs and influences the other, policy reform on integration will remain haphazard, at best. In most developing countries, primary health care facilities are used mainly by women and children, and integration has meant adding new activities to these existing services. For the vertical programs that support these services — family planning, malaria control, HIV/AIDS prevention and treatment — integration has implied collaboration rather than merged responsibility. Difficulties with integration have in some instances been worsened by the activities of external donors. At present, there is no consensus about how integration should be accomplished at the country level, and the set policy of a particular donor can sometimes result in bad practice.

Successful integration can be achieved only through political commitment to institutional collaboration. Simple expansion of vertical programs can never be the answer. At a time when the U.S. administration's stance is worsening the segregation of SRH from HIV/AIDS programs (which has an added effect in countries receiving funding from the President's Emergency Plan for AIDS Relief),

the counter-arguments need to be heard more strongly in the policy and political communities. In particular, the Global Fund to Fight AIDS, Tuberculosis and Malaria should also link SRH issues more concretely into its guidelines.

Mainstreaming is neither a panacea nor an end in itself. It is a means for enabling the SRH community — just like any other community with a specific niche and focus — to improve its capacity to contribute to the global fight against HIV/AIDS. It is of paramount importance that HIV/AIDS is seen as primarily a sexually transmitted disease, whose defeat will require the full resources and capacities of the SRH community. By working more closely with other sectors, without damaging its traditional activities, the SRH community can make a greater contribution to this global fight. And parallel to this, the HIV/AIDS community needs to incorporate natural linkages between existing programs, and broader sexual and reproductive health issues. For collectively we have the unparalleled opportunity to alter the course of the seemingly inevitable HIV/AIDS history. And this is a task to which we must and will rise. It seems so logical — doesn't it?

FILIPINO YOUTH — CONTINUED FROM PAGE 11

HIV prevention activities:

1. Take Advantage of Opportunities to Promote Dual Protection

The ASEP project provided an ideal opportunity for strengthening family planning within STD/HIV prevention activities. The project was strongly established in communities where groups at risk of HIV and unwanted pregnancy congregated. ASEP's behavior change strategy already promoted messages on partner reduction, condom use and dual protection. With a small infusion of funds, PRIME II was able to bolster outreach to youth on family planning, and strengthen referrals to government-run family planning clinics or youth-friendly pharmacies. Particularly as funding priorities shift, it is more critical than ever to maximize opportunities that allow for greater synergies among programs and, subsequently, greater health benefits to underserved populations.

2. Utilize and Build Capacity of Non-conventional Providers

There are populations that for one reason or another do not have adequate access to traditional, facility-based reproductive health care. Further, the capacity of national health care systems may not be sufficient to meet the health care needs of its entire population. Utilizing non-conventional health workers to provide counseling and information expands the ability of program managers to effectively reach and influence neglected or hard-to-reach groups' reproductive health behavior. There are tangible benefits to building health workers' capacities to provide information, counseling and referrals to reach groups with limited access to health care, as evidenced from

the project's findings. Every effort should be made to consider health care workers at all levels when promoting dual protection.

3. Target Youth

This activity was made possible through a special source of funds for reaching youth, and for good reason. Adolescence is a time when youth are most likely to experiment with sex, but are still too shy to take care of reproductive health care needs. Yet, they are very responsive to youth-friendly messages and messengers. Taking the time to talk to youth about HIV and pregnancy prevention can be a relatively inexpensive addition to a project yielding a broad impact on the effectiveness of both interventions.

4. Involve Community in Design of the Project

This project was successful in part because members of the target groups were involved in its design. Results of focus group discussions with young men and women prior to the implementation of the project revealed that youth did not like going to pharmacists for health information or condoms, instead relying on community health outreach workers and peer educators. Based on these findings, the original design of the project was revised to meet the informational needs of youth. Further, involving youth in the production of youth-oriented educational materials helps to ensure acceptance and ownership of the products' messages.

For more information, visit www.path.org

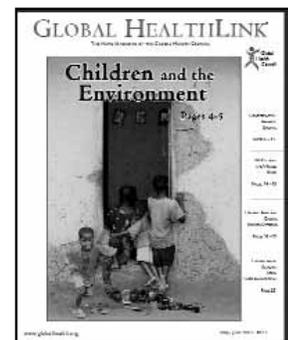
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Ensuring Privacy and Confidentiality in Reproductive Health Services, a training module and guide for service providers, is a joint publication from the **Global Health Council** and **PATH**. It can be downloaded in PDF format from http://www.globalhealth.org/images/pdf/privacy_module.pdf.

Also from the **Global Health Council** is *Commitments: Youth Reproductive Health, The World Bank and The Millennium Development Goals*. Funded by the William and Flora Hewlett Foundation, this report explains the link between youth reproductive health and achievement of the Millennium Development Goals, and identifies the World Bank as the primary agent to address poverty reduction and youth reproductive health. It can be downloaded in PDF format from <http://www.globalhealth.org/images/pdf/commitments.pdf>.

USAID's Regional Economic Development Services Office for East and Southern Africa has just published the *Handbook on Pediatric AIDS in Africa — For Medical Students, Doctors and Primary Care Workers*. Conceptualized to provide a simple, accessible and practical handbook for health professionals involved in preventing infection and caring for children infected and affected by HIV, the handbook can be accessed at <http://www.synergyaids.com/caba/documents/Pediatric%20AIDS%20in%20Africa.pdf>

EngenderHealth has released two new publications designed to reduce stigma: *Reducing Stigma and Discrimination Related to HIV and AIDS: Training for Health Care Workers, Training Manual* and a *Participant's Handbook*. (See page 14 for full story.) PDF versions can be viewed or downloaded at <http://www.engenderhealth.org/res/offc/hiv/stigma/>. CD and printed copies are also available by e-mailing materialresources@engenderhealth.org.

The **International Centre for Diarrheal Disease Research, Bangladesh** has an electronic and print journal, *Journal of Health, Population and Nutrition (JHPN)*, that covers HIV/AIDS issues. To view, visit <http://202.136.7.26/pub/publication.jsp?pubID=4844>. Manuscript submissions in electronic format are invited; e-mail jhpn@icddr.org.

<http://www.bmjlearning.com> is an interactive learning website run by the **British Medical Journal** for doctors and other clinicians who work in primary care. It includes interactive case histories, as well as learning modules on topics including "Testing for HIV in General Practice."

The Health InterNetwork Access to Research Initiative (HINARI) is aiming to bridge the gap of unequal health information distribution in the developed and developing worlds, by providing free, electronic access to articles in published health journals. The WHO, in collaboration with the BMJ Publishing Group, convinced the world's six largest medical journal publishers (Blackwell, Elsevier Science, Harcourt Worldwide STM Group, Wolters Kluwer International Health & Science, Springer Verlag & John Wiley) to provide access to all of their online journals for free or at deeply discounted rates through HINARI. Visit HINARI at <http://www.healthinternetwork.org/>

Management Sciences for Health has announced the publication of the 2003 edition of the *International Drug Price Indicator Guide*. Covering prices from 19 sources, the guide will be an invaluable resource for supply managers who

need to plan and compare pharmaceutical costs for program development. The print edition comes with a CD-ROM and can be ordered by e-mailing bookstore@msh.org, or by visiting the MSH eBookstore at <http://www.msh.org/resources/publications>.

Two new publications from YouthNet at Family Health International are: *Teacher Training: Essentials for School-Based Reproductive Health and HIV/AIDS Education — Focus on Sub-Saharan Africa* and *New Findings from Intervention Research: Youth Reproductive Health and HIV Prevention*. For more information on these publications or other items, please contact youthnet-pubs@fhi.org.

The U.S. Department of Health and Human Services (DHHS), Center for Faith-based and Community Initiatives, has released the *2004 Grants Notebook*, which details federal funding opportunities for faith-based and community organizations. It can be downloaded in PDF format at <http://www.hhs.gov/fbci/docs/FBICI2004GrantsNotebook.pdf> or the Center can be contacted by e-mail at CFBCI@hhs.gov.

Children coping with loss, grief or transition can be helped by the book, *Telling Our Stories*, launched by CARE International Zambia, and facilitated by Care International, Family Health International and USAID, through SCOPE OVC. The book can be viewed or downloaded from <http://www.synergyaids.com/caba/documents/telling%20our%20stories.pdf>.

The *International Standard Randomized Controlled Trial Number Register* has been set up by the World Health Organization (WHO) to make available the results of all clinical trials approved by the WHO ethics review board. Each trial has been assigned an International Standard Randomized Controlled Trial Number (ISRCTN). Free on-line access is available at <http://www.controlled-trials.com/>.

The Center on AIDS & Community Health at the Academy for Educational Development (AED) has launched a new **HIV/AIDS anti-stigma website**. This website is one component of an HIV/AIDS Anti-Stigma Initiative that the Ford Foundation is funding AED to implement. The site is accessible at www.hivaidsstigma.org.

The African Women's Media Center (AWMC), a project of the International Women's Media Foundation (IWMF), has produced a series of radio programs reported by African women journalists from Namibia, Nigeria, South Africa and Zambia that celebrate the courage of people living with HIV/AIDS. The programs are based on personal stories, six of which have been collected on a CD-ROM, entitled *Positive and Proud*. Limited free copies of the CD can be obtained from Erin Henk at ehenk@iwmf.org.

ActionAid in London has issued a new report, *Approaches to Estimating the Impact of HIV/AIDS on Teachers* that summarizes points of discussion from the first meeting of the UK working group on Education and HIV/AIDS. More information as well as a PDF of the report is available at <http://www.aidsconsortium.org.uk/Education/educationworkgroupseminars.html> or from ActionAid at <http://www.actionaid.org/resources/education/education.shtml>. A hard copy can be obtained by contacting Tania Boler, author of the report, at tboler@actionaid.org.uk.

SUPPORTING PRIMARY PROVIDERS — CONTINUED FROM PAGE 11

HIV/AIDS prevention. These protocols were translated into training curricula and now form the basis of job descriptions for doctors, nurses and midwives. After six months of interventions, assessment indicates strong provider compliance with the standards. Provider scores on STI/HIV knowledge tests have increased from 45 percent pre-training to 86 percent post-training, falling slightly to 81 percent at follow-up.

In 2003-04, PRIME II tested tools to help providers and health systems take advantage of opportunities to provide family planning counseling and services during prevention of mother-to-child transmission (PMTCT) of HIV services. Using performance improvement techniques, PRIME II identified missed opportunities for family planning counseling and service delivery during the implementation and scale-up of PMTCT services. Work continues on a 'gold standard' package that details essential FP messages at every client-

provider point of contact within the PMTCT program infrastructure. The goal of these tools is to optimize the contribution of both formal and informal providers to deliver the FP messages and services needed by pregnant women.

PRIME II integrates family planning and HIV/AIDS prevention programs to increase the number of primary providers offering life-saving family planning and HIV services. This is achieved by building capacity and improving the performance of primary health care providers, developing key messages that speak to pregnancy and HIV/AIDS, and addressing missed opportunities to integrate family planning into health care delivery.

Please see the PRIME II website for more information: www.prime2.org

SEPTEMBER 2004

The **16th Annual Conference of the Australasian Society for HIV Medicine (ASHM)** will be held Sept. 2-4 in Canberra, Australia. The 2004 theme for Australia's premier HIV event is *Positive Partnerships — From Policy to Primary Care*. Visit <http://www.ashm.org.au/conference2004> or contact conferenceinfo@ashm.org.au for registration details.

The Canadian HIV/AIDS Legal Network and the Interagency Coalition on AIDS and Development (ICAD) will hold a joint **Annual General Meeting** and skill-building workshops in Montreal on Sept. 10-12. Theme of this conference is *Promoting Healthy Public Policy in Canada and Around the World*. Full details are available at <http://www.aidslaw.ca/Maincontent/events/agm2004.htm>.

On Sept. 10-12, the **7th Annual Staying Alive Conference** will take place in Atlanta, GA. Organized by the National Association of People with AIDS (NAPWA-US), this event is a diverse national gathering of positive people and those who support them. Visit <http://www.napwa.org> for more information.

OCTOBER 2004

Oct. 1 is the deadline for both early bird registration and submission of abstracts for the **2005 AIDS Impact Conference, *The Moment is Now***, to be held April 4-7, 2005, in Cape Town, South Africa. Complete details are available at <http://www.aidsimpact.net>.

The **First Asia Pacific Women, Girls & HIV/AIDS Best Practices Conference** is scheduled to take place in Islamabad, Pakistan, on Oct. 4-6. The major objectives of the conference include: understanding the impact of HIV/AIDS on women and girls in the Asia Pacific region; determining the future impact of HIV/AIDS in the region; and reviewing strategies to reverse current trends in transmission and identify emerging issues of concern. The organizing agency is the AMAL Human Development Network, and more information is available on <http://archives.healthdev.net/sea-aids/msg00967.html> or by e-mailing mails@amal-hdn.org.

The **4th International Conference and Exhibition on Traditional Medicine** will be held Oct. 4-6 in Dakar, Senegal. The goal of the conference is to find an affordable and effective alternative anti-HIV medicine from natural products and traditional/alternative medical practices, to alleviate the sufferings of people

living with HIV, and to work with Western medicines to prevent and hopefully stamp out the disease completely. For more information, visit <http://www.africa-first.com/4thictm.asp>

Organized by the National Minority AIDS Council, the **United States Conference on AIDS (USCA)** will be convened Oct. 21-24 in Philadelphia, PA. This is the largest AIDS-related gathering in the U.S. The abstract deadline is May 7, and early bird registration is due by July 12 with a regular registration deadline of Sept. 20. Visit <http://www.nmac.org/conferences/usca2004/> for details.

Oct. 25-28 are the dates of the **Workshop on Adverse Drug Reactions and Lipodystrophy in HIV** to be held in Washington, D.C. The workshop this year will encourage discussion on metabolic complications and other toxicities relating to the long-term management of HIV infection in the developing world. Complete information can be found at http://www.intmedpress.com/lipodystrophy/main_cfm?sect=home.

NOVEMBER 2004

The **132nd Annual Meeting and Exposition of the American Public Health Association** will take place in Washington, D.C., from Nov. 6 - 10. Theme of this year's meeting is *Public Health and the Environment*, and registration information and other details can be accessed at <http://www.apha.org/meetings/>.

Working Under Fire: Drug User Health and Justice 2004 is the theme set for the **5th Annual National Harm Reduction Conference (HRC)**, which will be held at the Astor Crowne Plaza Hotel in New Orleans, LA, on Nov. 11-14. Registration details and other information are available at <http://www.harmreduction.org/conf2004/index.html>.

The **Association of Nurses in AIDS Care's 17th Annual Conference, *Unmasking HIV in the Big Easy***, will run from Nov. 15-18, in New Orleans, LA. The conference website is http://www.anacnet.org/conferences/2004_ANAC_National_Conference.htm.

Management of Behavior Change Communication Interventions is the title of a course sponsored by the Asian Pacific Development Communications Center. Running from Nov. 23 to Dec. 3 in Bangkok, Thailand. It will focus on the managerial aspects of behavior change communication (BCC) interventions. Emphasis will be placed on understanding the theoretical and analytical basis for BCC, and the consequent planning and

management interventions, including monitoring and evaluation. For more information, please visit <http://www.dpu.ac.th/adcc/>

Margaret Sanger Centre International is sponsoring the course **Training the Trainer: Low-Tech Strategies for Promoting Sexual Reproductive Health** from Nov. 1-12 in Johannesburg, South Africa. This training course will explore low-resource Sexual Reproductive Health (SRH) interventions, and will focus on developing innovative methodologies for learner-centered instruction in resource-constrained programs. Visit <http://www.msccsa.org.za/> for more information.

The German Foundation for World Population is sponsoring the **Reproductive Rights for Young Journalists Workshop** from Nov. 22-27, in Kampala Uganda. The training workshop is designed for both print and electronic media reporters and will seek to give participants new insights into the socio-economic impact of reproductive health and sexual rights in rural and peri-urban communities in Uganda. Contact Jordache Ellapen (ellapenj@witsplus.witz.ac.za) or the German Foundation for World Population's Uganda office at (dswuganda@africaonline.co.ug) for more information.

DECEMBER 2004

World AIDS Day is celebrated around the globe on Dec. 1. This year the **World AIDS Campaign 2004** will focus on *Women, Girls, HIV and AIDS*. A 23-page strategy paper and "A Guide on Developing a Campaign" are available for download from the UNAIDS website. Visit <http://www.unaids.org/en/events/campaigns.asp> for more information.

Mumbai, India will host an **International Social Work Conference on *Community Care and Support for Persons Living with HIV/AIDS: Challenges for the New Millennium***. Conference dates are Dec. 4-6. Organized by the College of Social Work, Nirmala Niketan, in Mumbai, the conference will focus on reviewing models of care and support programs for people with HIV/AIDS in both developed and developing countries, identifying best practices, developing training modules, and exploring methods of advocacy. The conference website is <http://www.nirmalaniketancollegeofsocialwork.org/>.

News Headlines from Around the Globe

AFRICA

Vitamins Help Extend Life for Positive Women

An eight-year-long Harvard study has found that a simple daily vitamin pill can delay the progress of AIDS in H.I.V.-infected women. While researchers said that the vitamins are not a cure or substitute for antiretroviral therapy, they said that vitamins are a cheap, safe way of giving malnourished women in Africa or Asia without access to ARVs extra months of life, and somewhat less misery before they die.

The study of 1078 pregnant Tanzanian women found that 30 percent fewer of the women who received the multivitamins died or progressed to full AIDS during the study than a group of women receiving a placebo. The counts of CD-4 cells, the immune system cells that the virus attacks, stayed somewhat higher in the group that took multivitamins. (*The New York Times*, July 1, 2004)



Rwanda to Offer Cost-Free ARVs to Citizens

Rwanda plans to offer free antiretroviral drugs to 90,000 HIV-positive people in the country by the end of 2004, Louis Munyakazi, head of the Treatment Research for AIDS Center. Currently, about 4,350 patients are receiving antiretroviral treatment in the country. The scale up of treatment will be funded by \$85 million in aid from the World Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the U.S. President's Emergency Plan for AIDS Relief. The treatment initiative aims to provide drugs for approximately 100,000 patients by 2007 and care for those affected by the epidemic, including AIDS orphans. A total of 250,000 people will benefit from the initiative by 2007, according to Munyakazi. (*AP/Chicago Tribune*, 8/16).

More Research Needed on Nevirapine

Further research is needed on claims from South Africa's Medicines Control Council that single-dose nevirapine, which is used to prevent mother-to-child HIV transmission, increases the risk of drug resistance, the country's Ministry of Health said. During the XV International AIDS Conference last month, the MCC said that the government would stop recommending the use of nevirapine as a monotherapy because of reports that it increased the risk of developing drug-resistant HIV strains by up to 50 percent. Although the regimen has become increasingly common in clinics throughout Africa, MCC recommended against administering a single dose of nevirapine to a pregnant woman before childbirth and also said that the drug is more effective when used in combination with other antiretrovirals (*Kaiser Daily HIV/AIDS Report*, 7/14/04).



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Chinese AIDS activist Li Dan (in white shirt) was briefly detained by local government officials in Henan province while preparing to join in a protest of government HIV/AIDS policies, *AFP* reported. Meanwhile, although Li was released days later, Zhu Longhua, a local doctor from Henan's Shuangmiao 'AIDS village' was reportedly arrested for "dispensing too much HIV medication." Of the village's population of 3,000, some 400 people are HIV-positive, as a result of selling their blood through unsanitary government-sponsored programs in the 1990s.

ASIA-PACIFIC

AIDS Poised as India's Greatest Killer

The World Bank has warned that the number of HIV-positive Indians could rise to 5.5 million a year by 2033 — more than the total number of existing cases — unless urgent steps are taken. Without a change in treatment policy and progress in prevention, HIV/AIDS will become the single largest cause of death in the world's second most populous nation, accounting for 17 percent of all deaths and 40 percent of infectious deaths, by 2033, the bank said in a report on HIV/AIDS in India. "Antiretroviral therapy is not going to have a big impact on the course of the epidemic," Peter Heywood, World Bank health specialist and one of the authors of the report, told reporters. (*Reuters*, 8/13/04)

WHO Removes ARVs from Prequalification List

For the second time in recent months, the World Health Organization has removed several Indian generic antiretrovirals from its prequalification list. Following the May removal of two Cipla combination that lacked adequate bioequivalence studies from their contract research organization (CRO), Ranbaxy is now facing a similar measure that affects their generic antiretrovirals. The antiretrovirals in question are triple fixed-dose combination pills containing lamivudine, stavudine, and nevirapine in two different strengths, and a lamivudine plus zidovudine

tablet. Fixed-dose combinations are cheaper and easier to take than other antiretroviral drugs and are a major part of drug access programs in the developing world. (*Biomedcentral.com*, 8/5/2004)

China Legalizes Methadone to Control HIV

The Chinese government has begun progressively legalizing methadone — a synthetic narcotic drug often prescribed as a substitute for heroin in the treatment of addiction — in an attempt to control injection drug use and HIV transmission, the *Knight Ridder/St. Paul Pioneer Press* reports. At least half of the estimated 1 million HIV cases in China are the result of shared needles among injection drug users, according to government statistics. Previously, the Chinese government sent illegal drug users to hospitals, forced them to do hard labor or publicly executed them. However, government officials have begun instructing local and provincial governments to implement needle-exchange and methadone programs as part of their health policies. (*Knight Ridder*, 8/12/04)

New Zealand to Screen Migrants for HIV

From early 2005, New Zealand will be undertaking HIV screening for migrants, as part of a comprehensive review of New Zealand's health screening requirements. Some changes relating specifically to tuberculosis screening have already been implemented. The full set of changes, including screening for HIV, and a wider and updated set of tests for other expensive-to-treat conditions, will be implemented in early 2005, for people seeking to be in New Zealand for longer than 12 months. While HIV-positive people may not, prima facie, meet the definition of "acceptable standard of health," waivers of this requirement will be available for family members of New Zealand citizens and residents, and for refugees. (*The Swiss HIV/AIDS Documentation Center*, 8/4/04)

Mandatory HIV Education for Chinese Students

Following recommendations by the education ministry that teaching on drug control and HIV/AIDS prevention should be strengthened during basic education, secondary schools in China's capital, Beijing, will soon be required to provide children with compulsory HIV/AIDS education. Schools in other Chinese cities are set to follow suit, according to officials at the Ministry of Education.

There will be four hours of HIV/AIDS-related education during each of the first three years of secondary education, covering the science of HIV/AIDS, how it spreads within populations, the social and economic threats of the disease, and information about effective disease prevention. (*SciDevNet*, 6/21/04)

Drug Trial Halted in Cambodia

Sex workers have refused to participate in a major HIV drug trial in Cambodia unless they are given full



News Headlines from Around the Globe

medical insurance to protect them against future illness. Cambodian Prime Minister Hun Sen has now intervened to stop the trial, which was part of an international study to see if Tenofovir, which is used to fight HIV, can also protect against the disease. "We are very happy with this order as we don't want to take part in this drug test. There is no safety guarantee for us," said Cambodian Women's Network for Unity director Kao Tha. But Dr. Ward Cates, president of Family Health International, which was running the trials said "The types of care being offered to any of the study participants was well beyond the standard of care offered in Cambodia and in other HIV prevention trials." (*BBC News*, 8/14/04)

India's Union Health & Family Welfare Shri Anbumani Ramdoss recently called for innovative methods to promote the use of condoms, particularly for dual prevention. Speaking at a function organized for launching of the Dual Protection Condom Program in New Delhi, Dr. Ramdoss said that public-private partnerships are essential in launching campaigns that promote condoms. Sponsored by USAID, the program is aimed at improving the image of the condom as an important aspect of family planning, and protecting against sexually transmitted diseases, particularly, HIV/AIDS. (*Government of India Press Information Bureau*, 6/30/04)

EUROPE

UK Migration Policy Could Exacerbate HIV
Britain's policy of relocating people seeking asylum there from London and Southeast England to other parts of the country may lead to an increase in HIV transmission, interruptions in antiretroviral drug

therapy and compromised HIV/AIDS care, according to a study published in the July 26 issue of *BMJ*. More than 100,000 people have been transferred under the U.K. National Asylum Support Service policy, which was instituted in 2000 to redistribute the cost of medical care. It is unknown what per-



centage of the people relocated under the policy are HIV-positive, but many come from countries with HIV/AIDS epidemics, according to the study. The researchers said, "Inappropriate dispersal of an HIV-infected patient could lead to HIV resistance, onward transmission of HIV infection and avoidable morbidity and mortality for the asylum seeker." The researchers concluded that the National Asylum Support Service should seek specialist advice before dispersals and consider the impact on the clinic in the area to which the person is being moved. (*Birmingham Post*, 8/6/04).

LATIN AMERICA

El Salvador Lifts Restrictions against PWHAs
Following India, El Salvador has become the second country to lift discriminatory measures against PWHAs, by repealing existing regulations requiring HIV testing for temporary and permanent residency permit applicants. Under the old regulations, anyone age 15 and older applying for temporary and permanent residency had to undergo HIV testing. (*The Swiss HIV/AIDS Documentation Center*, 8/4/04)

Brazil Rescinds ARV Plant Offer for Mozambique
Brazil has withdrawn its offer to build a drug manu-

facturing plant in Mozambique that would have provided the country with antiretroviral drugs to treat people living with HIV/AIDS, Agencia de Informacao de Mocambique/AIIAfrica.com reports. Pedro Chequer, coordinator of the Brazilian Ministry of Health's AIDS programs, said that Brazil would support quality control of drugs in Mozambique and transfer technology to the East African nation. However, Chequer said that Brazil would offer antiretroviral drugs to smaller Portuguese-speaking countries, including Guinea-Bissau, Cape Verde, Sao Tome and Principe and East Timor, instead of Mozambique, according to Xinhua News Agency. (*Kaiser Daily HIV/AIDS Report*, 8/16/04)

NORTH AMERICA

Canada to Provide Duty-Free ARVs
Stephen Lewis, the UN special envoy for HIV/AIDS in Africa, recently announced that the Canadian government has opened doors for African countries to purchase Canadian antiretrovirals (ARVs) at a duty-free price. Canada is the first country to legislate such a policy on ARVs, and it follows legislation introduced into the House of Commons in November 2003, where the country amended its patent laws to allow drug makers to manufacture and export generic versions of patented drugs to developing countries. Under the measure, about 50 countries would be eligible to receive generic drugs at a fraction of the prices charged in Canada. The law also calls for special markings and packaging for the generic drugs sold as part of a program to prevent them from being sold on the black market or re-imported into Canada. (*The New Vision*, 8/4/04)

www.globalhealth.org

The Global Health Council has launched an updated version of its popular website, www.globalhealth.org. In addition to a fresh look, the site offers a variety of new features designed to educate visitors and spur action on current issues.

All our publications, including back issues, are available on the website, so members from Vermont to Madagascar can have instant access to the resources on which they rely.

In the "Take Action" section, act on your concerns by signing up to become a volunteer with the Global Health Action Network and communicating your ideas to Congress. It is a simple, rewarding and effective action.

From a general overview of our mission to areas detailing activities of individual programs, health care professionals and concerned citizens alike will have the opportunity to learn more about our efforts and see how they can make a difference.

To learn more about the Council and to see the new website for yourself, visit us at www.globalhealth.org.





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Ambassador Randall Tobias (right) speaking with Global Health Council's VP for Policy, Research and Advocacy, Jim Sherry, at the Council reception for it's members.



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This traditionally-carved Thai candle was lit by UN Secretary-General Kofi Annan and Thai Prime Minister Thaksin Shinawatra at the conference's opening session, leading the audience in an International AIDS Candlelight Memorial, a program of the Global Health Council.



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Miss Universe 2004 Jennifer Hawkins, spokesperson for the International AIDS Candlelight Memorial, at the Council's conference booth with Executive Vice President Annie Bauer and President Nils Daulaire.



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Protestors outside the conference halls seeking enhanced access to treatment.



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Global Health Council President & CEO Nils Daulaire speaks at one of the conference's plenary sessions



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Inspiring Youth: Henry Hudson Luyombya

By JENNIFER HYMAN
MANAGING EDITOR, GLOBAL AIDSLINK

'Guess who?' queried the excited young man standing behind me, as he tightly wrapped his fingers across my eyes, adding to the suspense. Being at the Global Health Council's annual conference in Washington, DC, I knew I'd run into some old acquaintances, but I couldn't stifle my elation when I turned around and saw it was my good friend, Henry Hudson Luyombya.

I first met Henry last September in Nairobi, Kenya, at the International Conference on AIDS and STIs in Africa. He had immediately impressed me not only with his joyful spirit, his warmth and his kindness, but also with the depth of his knowledge about HIV/AIDS, and the amazing perspective he had about how communities were affected by the pandemic. A few weeks later, I met up with Henry again in his hometown of Kampala, Uganda, and watched him in action as a youth volunteer at The AIDS Support Organization's (TASO) headquarters, attached to Mulago Hospital.

Through TASO's AIDS Challenge Youth Club, Henry speaks about HIV/AIDS awareness in schools and communities, and on radio and television shows, as well as making home visits to child-headed households. "I firmly believe that listening to more youth voices will lead to fewer HIV infections," he says.

Albeit soft-spoken, Henry, 24, oozes inner strength. "I got to know my HIV status in early 2002, though, of course, I wasn't so open about it then."

Although he only learned he was infected with HIV two years ago, his life was affected long before then. "After my father died in 1990, my mother talked to my six siblings and me, and explained that the cause of his death was AIDS. She encouraged us to brave how others would treat us." Henry's brother has also died of AIDS.

Henry only revealed his serostatus to a select number of close and supportive friends at the outset, but the benefits of keeping his news private were quickly outweighed by the powerful role he was able to play for others, by becoming a public face of infected and affected youth.

"Not until the *Staying Alive* campaign's TV special, 'Meeting Mandela,' when I interviewed Nelson Mandela, did I become more open," Henry said. As part of Family Health International (FHI) and MTV Networks' *Staying Alive* educational media campaign, the hour-long "Meeting Mandela" special was offered rights-free to broadcasters including China's CCTV, India's Doordarshan, South Africa's SABC, Australia's Network Ten,

and many others, to reach a potential audience of up to 2 billion viewers.

Portions of Henry's interview with Mandela were also broadcast at a special reception honoring MTV's CEO Bill Roedy during a celebration sponsored by FHI at the Council's annual conference.

"I realize that my calling is to educate and sensitize young people to prevent new infections, and encourage them to open up and seek counseling and testing," explained Henry. He added, "I want

to advocate for more care and support for young people with HIV/AIDS, and increase their access to life-saving antiretrovirals (ARVs)."

Although TASO Mulago is offering ARVs to a select number of patients through a partnership with the U.S. Centers for Disease Control, and from a private donation made by U2's lead singer and AIDS activist Bono, Henry's doctors say his CD4 count is not yet high enough to warrant the therapy. But he still places great importance on the need for psychosocial support. "What has helped me is that I know how to live positively. I counsel myself and I count on my closest friends and family. I feel like I am a normal person. When I need support, they can give it to me."

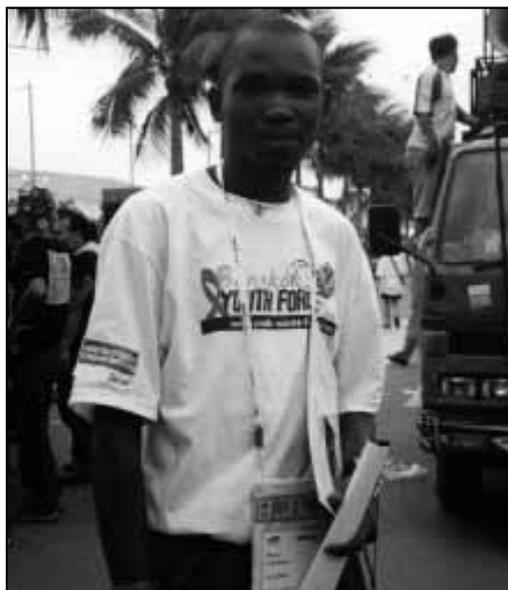
And in a very short period of time, Henry has burgeoned

into a young activist, not only presenting at conferences around the world, but also helping to create support networks for infected youth like him.

He explained, "Last year, after the International Conference of People Living with HIV/AIDS, some friends and I formed an organization called the Uganda Young Positives for people under 30." He is also part of the social club Positive Society, which is where he met his girlfriend, Maureen. "She's Kenyan, and we spend a lot of airtime calling or text messaging. Sometimes I text message her in the morning, reminding her to take her antiretrovirals."

After reading "Memories of Life before ARV Access" in issue #84 of *Global AIDSLink*, which profiled another TASO volunteer, Edward Ssemakula, Henry pulled me aside. "You know," Henry began with great care, "Edward has died of the disease."

As my eyes welled up with tears — thinking of the friends and family I have lost to HIV/AIDS — Henry once again proved the magnitude of his inner strength, and part of the reason he is so inspiring to others. "Don't be upset, it's okay," he said with a soft smile. "Death is as natural as life. What matters is making the most of your time while you're here."



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Henry Hudson Luyombya in Bangkok, Thailand, at the XV International AIDS Conference in July 2004



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