

**Supplementary Report**  
**Case Studies: Getting Research into Policy and**  
**Practice (GRIPP)**

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## Testing a Model to Improve Postabortion Care in Burkina Faso and Senegal

Factors	Pre-research	Research	Post-research	Scale-up Activities	Application/Utilisation										
<b>Research Process</b>	<ul style="list-style-type: none"> <li>Population Council approached by Head and Deputy Head of OB/GYN Dept at Dantec Hospital and Burkina Maternity Hospital in Senegal and Burkina Faso, respectively.</li> <li>Study designed by Population Council, CRESAR, CEFOREP, MoH in both countries</li> <li>Ethical standards assessed by ethical review committee in each country followed by Population Council's Internal Review Board</li> <li>Funded by USAID</li> </ul>	<ul style="list-style-type: none"> <li>Operations research to introduce and test improved model of PAC</li> <li>Research team included representatives from CRESAR/CEFOREP, MoH, donors, other stakeholders and service providers</li> </ul>	<ul style="list-style-type: none"> <li>Findings presented to stakeholders at one-day workshop. Feedback incorporated in final report and powerpoint presentation.</li> <li>Final dissemination seminar held for wider audience</li> <li>Policy recommendations made by CEFOREP</li> <li>Results accepted by MoH in both countries; ownership of PAC programme taken by the MoH</li> </ul>	<ul style="list-style-type: none"> <li>Staff in Burkina Faso trained first Senegalese doctors in PAC</li> <li>Project trained both doctors and midwives, enabling latter to play a greater role</li> </ul>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #cccccc;">Evidence Base</th> </tr> </thead> <tbody> <tr> <td> <ul style="list-style-type: none"> <li>Similar study carried out by CEFOREP and JHPIEGO with UNFPA support in regional hospitals</li> </ul> </td> </tr> <tr> <th style="background-color: #cccccc;">Advocacy</th> </tr> <tr> <td> <ul style="list-style-type: none"> <li>CRESAR, CEFOREP, with technical assistance of JHPIEGO advocated for policy change</li> </ul> </td> </tr> <tr> <th style="background-color: #cccccc;">Policy</th> </tr> <tr> <td> <ul style="list-style-type: none"> <li>MOH in both countries developed national norms and standards on PAC</li> </ul> </td> </tr> <tr> <th style="background-color: #cccccc;">Programmes</th> </tr> <tr> <td> <ul style="list-style-type: none"> <li>Trainers from Burkina Faso and Senegal trained staff in Benin, Cote d'Ivoire, Guinea, Haiti, Madagascar and Mali</li> <li>PAC programme expanded to regional, district and community levels in Senegal.</li> </ul> </td> </tr> <tr> <th style="background-color: #cccccc;">Practice</th> </tr> <tr> <td> <ul style="list-style-type: none"> <li>CEFOREP and EngenderHealth expanded services to district health centres in Senegal with support from FRONTIERS</li> <li>MoH in Burkina Faso and Senegal plan expansion of services to regional hospitals based on final study results.</li> <li>Decentralisation in Senegal allowed implementation of study recommendations in district hospitals without approval of MoH</li> </ul> </td> </tr> </tbody> </table>	Evidence Base	<ul style="list-style-type: none"> <li>Similar study carried out by CEFOREP and JHPIEGO with UNFPA support in regional hospitals</li> </ul>	Advocacy	<ul style="list-style-type: none"> <li>CRESAR, CEFOREP, with technical assistance of JHPIEGO advocated for policy change</li> </ul>	Policy	<ul style="list-style-type: none"> <li>MOH in both countries developed national norms and standards on PAC</li> </ul>	Programmes	<ul style="list-style-type: none"> <li>Trainers from Burkina Faso and Senegal trained staff in Benin, Cote d'Ivoire, Guinea, Haiti, Madagascar and Mali</li> <li>PAC programme expanded to regional, district and community levels in Senegal.</li> </ul>	Practice	<ul style="list-style-type: none"> <li>CEFOREP and EngenderHealth expanded services to district health centres in Senegal with support from FRONTIERS</li> <li>MoH in Burkina Faso and Senegal plan expansion of services to regional hospitals based on final study results.</li> <li>Decentralisation in Senegal allowed implementation of study recommendations in district hospitals without approval of MoH</li> </ul>
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<b>Stakeholder involvement</b>	<p><b>Stakeholders:</b> Technicians/health service providers, MoH, donors.  <b>PRE-RESEARCH:</b> MoH in both countries involved in the study design. Research idea advocated at meetings and workshops.  <b>RESEARCH:</b> Decision makers kept involved in the study, which ensured the study was appropriate to local context.  <b>POST-RESEARCH:</b> Invited to make suggestions for inclusion in the final report</p>														
<b>Communication</b>	<p><b>RESEARCH:</b> Periodic updates on study progress to policymakers  <b>POST-RESEARCH:</b> Dissemination seminars held in Dakar (Senegal), Bobo and Ouagadougou (Burkina Faso)            Results presented at several regional and international conferences.            Written reports and summaries produced in French and English.</p>														

**Macro  
Contextual  
factors**

- Policymakers and advisors had until then perceived illegal abortion to be a problem, but only considered addressing it as a way to reduce maternal mortality. It was essential to get their support and involvement in the study if the results were to be accepted and scaled up.
- Postabortion care often confused with abortion, which is a controversial issue and so dissemination of messages had to be done carefully.
- Some religious groups continue to oppose abortion

## Testing a Model to Improve Postabortion Care in Burkina Faso and Senegal

### Description of Research

Population Council has been involved in post-abortion care (PAC) projects in several English-speaking countries in east and southern Africa as well as in Egypt and Latin America. Most of the unanswered questions related to this issue are the same everywhere. However, the Francophone countries have lacked capacity to address them until recently. In 1997-98 the Population Council, with support from USAID, collaborated with Ministries of Health (MoH) in Burkina Faso and Senegal to introduce and test, through operations research, a model of improved PAC in order to help decrease mortality and morbidity associated with incomplete abortions. The studies also sought to estimate and compare the cost, feasibility and acceptability of pre- and post-intervention care, and to establish sites to serve as models for training in PAC. Interventions included improved emergency treatment procedures and family planning services, along with high quality counselling in five referral-level teaching hospitals. Both operations research studies employed a quasi-experimental pre-test/post-test design without a control group. Researchers interviewed maternity ward staff and post-abortion patients and collected cost data. Study results showed: restructuring of PAC services made them more efficient and cost effective; manual vacuum aspiration reduced the risks to patients, cost and time spent in hospital; and on-site family planning services resulted in higher contraceptive acceptance rates.

### Research Process

#### *Pre-Research Stage*

The Head of the OB/GYN department at Dantec Hospital in Senegal and the deputy to the Head at the Burkina Maternity Hospital first approached the lead investigator at the Population Council with questions, which initiated discussions between Population Council and the two hospitals about the possibility of an operations research study. Dr. B Thiéba says that the head of the gyno-obstetric department at University Maternity Hospital (UMH) in Burkina Faso, who occupies the post of president of the research unit in reproductive health, basically instigated this study of post-abortion care. She was also responsible for maternity and so it was an opportunity for them to experiment with abortion aftercare at the hospital.

When Population Council started writing the project proposal with both CRESAR (the Burkina Faso chapter of the Reproductive Health Research Network) and CEFOREP (Center for Training and Research in Reproductive Health, Senegal), they adapted and formulated the research question together as a team. Population Council is responsible for the creation of both CEFOREP and CRESAR. In the case of CEFOREP, Population Council funded its research unit while CRESAR was designed and created by Population Council as the Burkina Faso chapter of a regional reproductive network and its headquarters were established at the Population Council's regional office in Dakar.

The issue of maternal mortality and morbidity is well known and is among the highest priorities of the MoH in each study country. A literature review, findings from the Population Council Situation Analysis studies in each country, and baseline data from the maternity hospitals convinced the MoH that this was a problem to be addressed urgently. The MoH in both countries got involved later in the design of the study along with the Population Council, CRESAR and CEFOREP, and the Obstetrics and Gynecology Clinic at Le Dantec University Teaching Hospital in Senegal. The design and methods were the most appropriate to the local context and to the research team's knowledge. The MoH in each of the two countries has been working with CEFOREP and CRESAR on other research issues and hence the credibility of the research team was already well established.

While it would have been much easier to conduct the studies as independent projects in individual hospitals, the partners agreed to wait for the MoH's endorsement as in this way the small-scale pilot projects could impact the national health care system through changed norms, protocols and policy. In

each country, researchers attained the support of key policymakers before beginning activities. The research idea was informally discussed with the stakeholders and later advocated during workshops and meetings.

The primary audiences identified were hospital staff (providers and administrators), government policymakers and advisors. Secondary audiences were medical staff at lower level public health centres and private practices, the general public, the reproductive health community in Senegal and Burkina Faso and in neighbouring countries.

### ***Research Stage***

The Population Council played the role of catalyst and also provided technical assistance to the research teams. The research team in each country comprised of staff from the research organisation (CRESAR or CEFOREP) and an advisor to the MoH represented the MoH. Also on the team were other stakeholders and service providers, and representatives from donor organisations. Training was provided by Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO) and they were always represented at all levels.

The hospital staff was very much involved in the actual study. In the case of the University Maternity Hospital, for instance, the whole staff group within the gyno-obstetric department participated confirms B Thiéba. The Directors of the maternity hospital were involved; in the context of training, nearly all those in the health unit who were to be involved in the implementation were trained. The University teachers were also trained as it was they who were at the forefront in the early stages of the study.

The continued involvement of decision makers in the study ensured that the model tested was appropriate for the local context, and that the MoH as well as the other project participants had an investment in making the study a success. In both projects, dissemination of study progress began before any results were available, in the form of periodic updates to appropriate policymakers.

T Dieng of CEFOREP confirms that the research team ensured that the ethical standards were adhered to throughout the study. Clients were informed about each step of the care procedures and the fact that in addition to counseling, local anesthesia would be administered by medical personnel to control pain. This was conveyed in advance to clients participating in the study by providing them with comprehensive information, which they had to give their consent to. B Thiéba also confirms that at UMH, they insisted that the standards and ethics of the study be respected. Any patient who did not want to be involved in this part of the study was excluded. Even before the start of these services they spelt out the protocol of care. These provided a base for the development of protocols in all the sub-regions. A workshop was held to discuss the JHPIEGO documents and protocols developed on PAC; Dr Blandine was part of the team that drew up the norms and protocols of reproductive health care and she took advantage of this role to introduce the protocols in their services.

### ***Post-Research Stage***

The preliminary findings from the data analysis were compiled and presented for comments at a one-day round table workshop for stakeholders and suggestions made were used in the final report and for Powerpoint presentations for a wider audience. In Senegal, CEFOREP with technical assistance from Population Council took the lead in presenting the findings at both events. The final dissemination seminars in both countries were attended by regional and local policymakers, administrators, providers and representatives from most of the national and international NGOs in those countries. CRESAR, CEFOREP and local health officials also organised a number of regional meetings, and on their own initiative, some individuals who attended other dissemination seminars discussed the results at staff meetings within their organisations to promote the adoption of new practices. Final recommendations were made during the small sessions workshops held during the day of the dissemination seminar and were incorporated in the final report.

CEFOREP's policy recommendations for Senegal were:

- to develop advocacy activities directed at decision-makers and leaders of opinion in order to create an awareness of the necessity to consider complications of abortion as a major problem of public health;
- to validate the norms and protocols in PAC and to evaluate their impact on the improvement of the quality of services;
- to include the products, materials and equipments that are essential for the treatment of incomplete abortions in the routine expenses of the sanitary structures, in order to assure a perpetuation of the programme.

UMH recommended that the practices be decentralised and that there be prerequisites, because of the AIDS pandemic. Good practice in prevention of infection had to be ensured or one would risk transmission not only of AIDS but also viral hepatitis. Besides this, B Thieba says they had already thought of determining to what extent they could include the study findings in the basic training curriculum, so that it would not be necessary to repeat the training constantly.

The release of the study findings was timely according to B Thieba. UMH planned in such a way that following the study, the same conditions were reconstructed at ministerial level, because they had seen that it was a method of management which facilitated access to care and improvement in the quality of the services. The Santé Familiale et Prévention du SIDA (SFPS) project which had been fostered by JHPIEGO helped this research lead to the introduction of certain practices to prevent infection in almost all units in Burkina Faso. Perhaps if UMH had waited instead of taking this initiative, the benefits would have been limited only to UMH and the other pilot hospitals.

### **Communication**

The findings were presented at many international conferences in the USA and in Africa for nearly a decade and continue to be presented eg. American Public Health Association Conferences, several Protities conferences in South Africa, PAC conferences in Mombassa, Kenya organised by AVSC and other NGOs, Entebbe conference on Reproductive Health, Dakar March 2002, conference on PAC to share the Burkina and Senegal project results with other countries' delegations. CEFORP has presented the findings at the fifth Congress of the African Society of Gynaecology and Obstetrics (ASGO) in 1998 at Dakar and the third African Conference on Population and Development in 1999 at Durban with financial support from Population Council.

Written reports and summaries in both French and English have been produced and distributed. Apart from the study report which was disseminated widely in Burkina Faso and Senegal and in most West African Francophone countries, Power Point presentations were used for forums largely attended by scientists and medical personal involved in PAC activities.

The most important document produced based on the study findings according to T Dieng of CEFORP is the analytical report of the African Francophone PAC Conference in 2002.

A hindrance to the national implementation of the policy change is the insufficient diffusion of the study findings and recommendations. Most dissemination took place in urban areas, so there is a need to ensure national coverage/attendance, with providers taking a more active role. In addition, a clear MoH mandate is considered necessary for attaining widespread change.

### **Scale-Up and Application**

The leadership and commitment of the Heads of Maternities and the Reproductive Health divisions of the Ministries of Health during and after the study contributed a great deal to utilisation. T Dieng confirmed that a research proposal is currently being prepared to evaluate the PAC programme in two/three countries.

### *Advocacy*

Following the studies' conclusions both CRESAR and CEFOREP, with technical assistance from JHPIEGO, continued to use the results and recommendations to advocate for policy change within health facilities and in national norms.

At the time of the reconstruction of the results, the training and extension of services, the study participants at UMH advocated that these care services should be perpetuated, involving those responsible for health care and regional health management confirms B Thieba. The MoH has also accepted its introduction. The advocacy work has been carried out by the groups participating in the study, the hospital, the university, and DSF (Management of Family Health) which sponsored UMH. JHPIEGO also helped until recently, initiating them into advocacy work and assisting them until the SFPS Project was withdrawn. Advocacy activities are still carried out by UMH, but it is not as focussed as previously. The messages are directed towards service providers and hospital managers. One of the weaknesses is in the community sector. UMH have not studied anthropology to evaluate the impact of these types of care and to determine what people think of PAC, and this would be useful knowledge to improve its usage.

### *Policy*

Prior to 1997, neither Burkina Faso nor Senegal had an explicit policy or protocols regarding post-abortion care. Following the study, the MoH in Burkina Faso collaborated with CRESAR to develop and adopt national norms and standards regarding post-abortion care. Assisted by study partners, the MoH in Senegal developed national service delivery protocols based on those developed by CEFOREP.

In terms of adhering to national norms and standards for PAC, UMH has not experienced any difficulties since those who developed them are now the ones who have to implement them. These norms and standards were also used when training other staff at the hospital.

### *Practice*

Decentralisation in Senegal allowed maternity chiefs in hospitals and midwives in district health centres to implement study recommendations independently, without seeking central approval from MoH authorities. The projects trained nurses and midwives as well as doctors, so midwives were able to manage most cases and call upon doctors when complications were present. This arrangement was acceptable to the midwives, because they now had more responsibility and independence, and experienced greater job satisfaction. Doctors, in turn, could attend to patients more in need of specialised care. PAC has recently been incorporated in larger emergency obstetrical care and therefore funding for PAC supplies and commodities is also included in the budgets. Availability of PAC kits in the region has been a serious problem until recently but is now being provided by the IPAS team.

In both countries, expansion to all the regional hospitals and to the districts in the case of Senegal is underway. Currently CEFOREP and EngenderHealth, with the support of the Population Council's Frontiers in Reproductive Health Program (FRONTIERS), are expanding services to district-level hospitals and health centres. Following Senegal's lead, Burkina Faso's MoH and CRESAR are poised to begin a phased expansion to regional hospitals.

The UMH study participants first tried to diffuse the study results within the hospital. They asked the hospital to replicate certain positive points from the study in other services, notably prevention of infections. The study participants had to train doctors in other services, the coordinators of health units, and cleaning staff. All these measures were taken with the help of the management. Certain providers in the other services were also trained in certain aspects, for example, in ways to greet patients as a study



had showed that in Burkina Faso, the way patients are welcomed prevented some people from attending the health units.

Certain factors have worked against further utilisation. Some religious groups insist that providing any PAC is condoning abortion and that morbidity and mortality should remain high as a deterrent, while some politicians remain worried that any association with abortion will damage their image.

Key informants in health facilities attributed the lower utilisation in Burkina Faso (in relation to Senegal) to the Population Council's absence in post-study activities. As a research organisation, the Council considered its role fulfilled once the results were disseminated to the relevant audiences. Expansion was considered to be the responsibility of a service delivery organisation. However, many key decision makers considered PAC to be a Population Council project and expected more support. This differed from the situation in Senegal, where JHPIEGO and CEFORP maintained an active role in expansion through a follow-up project.

B Thiéba defends the withdrawal of Population Council from Burkina Faso saying that if responsibility for implementation is always placed with the organisations that help the stakeholders, there will be no advancement. She believes this is the responsibility of the MoH. The problem in Burkina Faso is that at ministerial level, people no longer practice public health and so often forget the importance of acting on what is learnt from such studies. It is difficult to determine what the role of the Population Council would have been in scale up, since its role was to assist with the research. Instead of the Ministry assisting, the hospitals had to appeal to partners who had financed them. Recently UNFPA took charge and asked UMH to train more providers in their zones, a responsibility that should have been taken by the Ministry. There is no one specific person in charge of implementation at the Ministry either. At the training level efforts have been made at the ENSP (National School of Public Health). At the university level too, efforts are being made though much is yet to be done (hospital staff are also university staff).

There have been problems at the hospital level too according to B Thiéba because of the hospital management who viewed the initiative as merely research and not relevant to them. It is also a question of personality and of who is in charge. When the venture was seen as being financially profitable, they began to get interested.

The maternity sections of the two participating hospitals in Burkina Faso are considered as training sites and so there is the possibility of developing training tools based on what was used during the study training. The same materials have already been used to train providers in Guinea, Senegal and even Haiti. Senegal too has trained other countries since then.

In terms of scale up to include rural hospitals in Burkina Faso, B Thiéba says that to begin with they attempted to extend the programme and were fortunate to have JHPIEGO with them until the extension. But the main problem was when JHPIEGO tried to involve others. The Ministry does not prioritise scale up to rural hospitals, perhaps because it was not included in ministerial plans at the start. While the Ministry accept the need for it, they have not been persuaded to act on the suggestions. They do view post abortion care as being important but it stops there. In Burkina Faso, legalisation of abortion has not yet evolved.

No evaluation has yet been made in Burkina Faso to see what the impact of introducing changes has been. At present at UMH they are leading a situational analysis of these services in the centres that have been trained. It would be desirable to do a study to see what the impact of the care on the health of the women has been in the clinics/centres to see whether these services have facilitated access to abortion aftercare, whether it has improved health, whether it has allowed women to access other services. B Thiéba says such findings would be important for people to know and if it is found that it does not work, they should discontinue these initiatives.

## PUBLICATIONS

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2. Centre de Formation et de Recherche en Santé de la Reproduction, Africa OR/TA Project II, JHPIEGO and Clinique Gynecologique et Obstetricale Chu A. le Dantec, 1998. *Introduction des Soins Obstetricaux d'Urgence et de la Planification Familiale pour les Patientes Presentant des Complications Lieés a un Avortement Incomplet*. Population Council: Dakar, Senegal. For more information, contact: [pcdakar@pcdakar.org](mailto:pcdakar@pcdakar.org) <http://www.popcouncil.org/pdfs/aor/sen8.pdf>
3. *Upgrading Postabortion Care Benefits Patients and Providers in Burkina Faso*. 1999. Operations Research Summary Number 3. Frontiers in Reproductive Health (FRONTIERS). Population Council: Washington, D.C. <http://www.popcouncil.org/pdfs/frontiers/orsummaries/orsum3.pdf>
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8. Le Comité de l'Initiative Francophone de soins après avortement (SAA). 2004. "Questions aux soins après avortement : extension des services en Afrique francophone." Washington, DC: USAID/AFR/SD et SARA/AED. [http://www.popcouncil.org/frontiers/projects\\_pubs/topics/pac/pac\\_af.html](http://www.popcouncil.org/frontiers/projects_pubs/topics/pac/pac_af.html)

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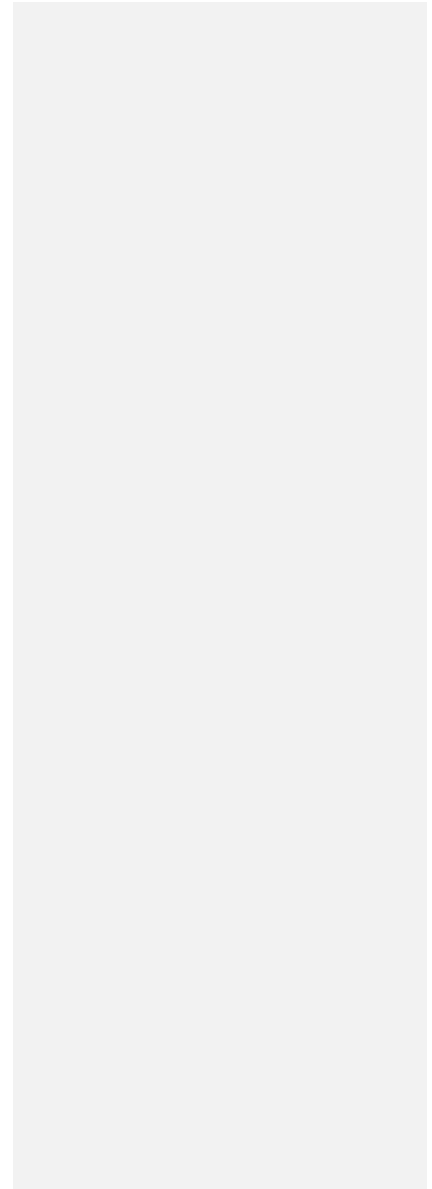
### Pharmacists' role in managing sexually transmitted infections: policy issues and options for Ghana

Factors	Pre-research	Research	Post-research
<b>Research Process</b>	<ul style="list-style-type: none"> <li>• Problem identification through literature review and baseline survey</li> <li>• Research questions developed in consultation with all key stakeholders</li> <li>• Research addressed two pressing gaps of policy importance</li> <li>• Ethical approval obtained from MoH, Ghana</li> </ul>	<ul style="list-style-type: none"> <li>• The interventions research involved implementation of STI training schedules with c.500 pharmacists and evaluation of whether this positively changed practice.</li> <li>• Evaluation done through pseudo patients: 248 pharmacies were each visited by 6 pseudo patients.</li> <li>• Methods approved by policy and ethics stakeholders and considered rigorous by research partners</li> <li>• Research team made up of representatives from HRU, NACP, Pharmaceutical Society, Pharmacy Council, LSHTM, WAPCAS</li> </ul>	<ul style="list-style-type: none"> <li>• Findings disseminated to key stakeholders and through MoH and pharmacy bodies to their members</li> <li>• MoH and pharmacy bodies agreed a set of recommendations and requested scale-up of training.</li> <li>• Release of study findings well timed as MoH and stakeholders ready to act on findings.</li> </ul>
<b>Stakeholder involvement</b>	<p><b>PRE-RESEARCH:</b> Key opposing stakeholders invited, and accepted, to be part of research team thus maximising credibility</p> <p><b>RESEARCH:</b> Collaboration of MoH and pharmacy bodies in design of research and training schedules meant the research was credible and feasible – it could not have been without cooperation of the Pharmacy bodies.</p> <p><b>POST-RESEARCH:</b> Involvement of key policy stakeholders representing both 'factions' (MoH and pharmacy bodies) and respected research institutions meant results were seen as credible.</p>		

- Positive research findings on efficacy of training schedules led to request from MoH to scale-up training.
- Pharmacy bodies agreed to assist in conducting further training with their members and new trainees in collaboration with WAPTCA.
- Training schedules developed during research now used by MoH and Pharmacy training bodies

Application/Utilisation
<b>Evidence Base</b>
<ul style="list-style-type: none"> <li>• Research contributed significantly to national evidence base on extent and appropriateness of pharmacists' treatment of STIs.</li> <li>• Several national reports and at least one journal article were produced.</li> <li>• Abstract presented at the XII International HIV/AIDS Conference, Geneva, 1998</li> </ul>
<b>Policy</b>
<ul style="list-style-type: none"> <li>• Research informed MoH policy to support training of pharmacists in treatment of STIs.</li> </ul>
<b>Programme</b>
<ul style="list-style-type: none"> <li>• Findings used to develop training schedules that are now utilised by MoH and Pharmacy training bodies</li> <li>• Course on Management of STI in curriculum of School of Pharmacy</li> </ul>
<b>Practice</b>
<ul style="list-style-type: none"> <li>• Improved counselling skills and partner tracing by pharmacists</li> <li>• Wider use of effective drugs against STIs</li> </ul>

<b>Communication</b>	<p><b>PRE-RESEARCH:</b> 'Opposing' stakeholders from MoH and pharmacy bodies engaged in discussions by WAPCAS and brought on board.</p> <p><b>RESEARCH:</b> Took place between key stakeholders at various points in the research.</p> <p><b>POST-RESEARCH:</b> Dissemination through: workshops, meetings, reports and by Pharmacy bodies to their members</p>
<b>Macro Contextual Factors</b>	<p>Historical tensions existed between the medical profession and the pharmaceutical community. WAPCAS addressed this by bringing both groups together and involving them in the study right from the start.</p>



## **Pharmacists' role in managing sexually transmitted infections: policy issues and options for Ghana**

### **Description of Research**

Since the publication of research suggesting that proper treatment of STI could reduce HIV incidence by as much as 40%, there has been much focus on best strategies for tackling STIs. In Ghana, as in many countries, pharmacists are the most common source of STI treatment and the objective of this research, which took place between 1997-1999, was to ascertain whether with focused training interventions, the quality of pharmacists' treatment of STIs could be ensured.

The project was a collaboration between the Ministry of Health Research Unit, the Pharmaceutical Society of Ghana (responsible for continuing training), the Pharmacy Council of Ghana (professional standards regulator and registration) and the CIDA-funded West Africa Project To Combat HIV/AIDS (WAPCAS).

The pre- and post-intervention findings suggest that pharmacists have a crucial role in effective management of STI, particularly in the management of urethral discharge. They may need to limit their management of genital ulcer to referring customers to laboratories and medical practitioners. They also represent a currently under-utilised opportunity for preventive activities. Regulation and quality assurance issues need to be addressed by both pharmacy and medical professions.

### **Research Process**

#### ***Pre-Research Stage***

Studies on the itinerary of STI patients in Ghana had shown that patients prefer buying drugs from a pharmacy; very few actually go to hospitals for these. The issue of how appropriate or feasible it is for pharmacists to treat STIs was therefore already a topic of some importance and there had already been discussions among the Ministry of Health (MoH), the Pharmaceutical Society and the Pharmacy Council. In 1996, the syndromic approach was taught to few health practitioners. The new molecules, i.e. Ciprofloxacin, doxycycline, etc. were not largely available in the country. As a project willing to deal with proper management of STI among vulnerable groups, WAPCAS encouraged a mixed approach: to strengthen the capacity of health providers including pharmacists to properly manage STI and, to encourage the availability and use of the new molecules for managing STIs.

The research aimed to fill two identified gaps:

1. The extent to which pharmacists are used for STI treatment in Ghana
2. The efficacy of allowing pharmacists to treat STIs

Two systematic methods were used to clarify the problem and inform the intervention:

1. Existing literature was surveyed to identify what was already known about the potential for pharmacists to treat STIs, the issues involved to assess the extent of knowledge of the situation in Ghana
2. A baseline survey was undertaken to assess the extent and quality of pharmacists' treatment of STI in Greater Accra and gather situation analysis information to facilitate planning and implementation of training activities.

From its inception this project was intended to be a collaboration between the MoH Research Unit, the Pharmaceutical Society of Ghana, the Pharmacy Council of Ghana, and WAPCAS, a support project to the MoH.

Historically there have been tensions between the medical profession, represented by the MoH and the Pharmacy profession, represented by the Society and the Council. The MoH had previously been reluctant to allow pharmacists to 'treat' referable medical conditions such as STIs, which require antibiotic treatment that should be dispensed by prescription. Legally the position of pharmacists being able to prescribe antibiotics is ambivalent. Pharmacists maintain that they have more knowledge than medics of the best treatments and combinations necessary for diseases and that they are as highly qualified in their specialist field.

WAPCAS, which already had a close link with the MoH, having its offices next to those of the Health Research Unit of the MoH, took the initiative to bring together both the MoH and the Pharmacy representative bodies, right from the beginning of this research. One of the priorities of the WAPCAS Ghana component was to build a cooperative relationship with the pharmacies, to enlist them in an effective anti-STI campaign. As of January 1997, WAPCAS initiated formal contact with officers of the national association of pharmacists, to bring them up to date on the Project's thrust, and on the role that they wanted pharmacists to play.

The composition of the research team, made up of representatives from the HRU, NACP, Pharmaceutical Society, Pharmacy Council, London School of Hygiene and Tropical Medicine (LSHTM), and WAPCAS, helped maximise its credibility – and therefore the final results – with both 'camps'. O Bruce, a Ghanaian Pharmacist who participated in the study says, however, that the Pharmaceutical Society was not involved in the design of the study, nor was it represented on the actual research team or any formal or informal body overseeing the research process. WAPCAS commissioned the MoH Health Research Unit to carry out the baseline survey to assess the extent and quality of pharmacists' treatment of STIs in Greater Accra and to gather situation analysis information to facilitate planning and implementation of training activities. Although the MoH carried out the baseline survey, care was taken to ensure that the questionnaire was developed through collaboration with, and extensive comments from, the Pharmaceutical Society, the Pharmacy Council, Health Research Unit (HRU) and the National AIDS Control Programme of the MoH, as well as WAPCAS personnel. Analysis was undertaken with technical assistance from LSHTM at the request of the MoH.

According to O Bruce, while the study was not a key priority for the Pharmaceutical Society and its members, it was well timed, as all the stakeholders were ready to act on the findings.

### ***Research Stage***

Training interventions were developed based on findings from the baseline survey, and training sessions were conducted for practising pharmacists in the region and further sessions for pharmacists.

The development of the training intervention was a collaborative effort and the training sessions was conducted by a team consisting of: the Manager of the National AIDS Control Programme (MoH), the STI/HIV regional co-ordinator (MoH), facilitators from the Pharmaceutical Society and WAPCAS, and other MoH resource personnel. According to Dr Khonde of WAPCAS, permission for the training programme was not required from the Medical Council as it had the backing of the NACP and MoH. Moreover, the Pharmacy Council and Pharmaceutical Society showed eagerness to buy into the programme. Executives of these two boards were amongst the participants at the first training session and soon after, made it compulsory for all their members to undergo the STI training course as part of their Continuous Learning Programme.

A post-training evaluation was also carried out using pseudo patients to assess the extent to which pharmacists had assimilated their training and the efforts made in transferring that information to their employees who were not pharmacists themselves. 6 pseudo patients visited each pharmacy (248 in total) pretending to have an STI symptom (either discharge or genital ulcer). This was carried out by HRU personnel and analysed by HRU and WAPCAS with technical assistance from the Centre for International Health, University of Sherbrooke.

The research methods, including questionnaires and pseudo-patient checklists, and the training schedules are fully documented. Pending funding, these can be replicated in other parts of the country, and with adaptation, in other countries of a similar setting.

Communication was undertaken by and between key stakeholders at various points in the research. O Bruce states however that progress updates on the study were not provided to the pharmaceutical community, except at the end of the study. In general, however, a cordial relation was maintained between all stakeholders throughout the study.

### ***Post-Research Stage***

The study findings were shared with all stakeholders who had been involved in the project, in both the medical and pharmacy professions, through in-country workshops, meetings and dissemination of reports.

The fact that all key policy stakeholders (MoH, Pharmaceutical Society, Pharmacy Council) were involved in the design and implementation of the study meant that the research and its results were seen as credible, timely and of sound quality. O Bruce confirms that the study recommendations were easy to apply in practice. The public health implications of the research were also adequately communicated.

Both the MoH and Pharmaceutical Society and Council recognise that there is still some way to go, but their collaboration on this project (for the first time) has encouraged debate and discussion between these two, often hostile, groups of actors. In particular they identified the following points for future action:

- Ensure that all pharmacists receive training on the national guidelines for syndromic management of STIs;
- Encourage pharmacists to assist in preventative activities such as promoting condoms and displaying posters;
- Incorporate STI management into pharmacy training curricula;
- Clearly define pharmacists' roles in STI treatment including limitations and when to refer;
- Share responsibility for controlling pharmacists' activities between pharmacy regulating bodies and the MoH to avoid possible tensions and controversies.

### **Scale-Up/Application**

After the findings were disseminated, the MoH asked WAPCAS to collaborate to scale-up the training initiative. In addition to almost 500 pharmacists trained during the research, in 1999 a further 90 qualified pharmacists and 100 final year pharmacy students were trained in Kumasi, Ghana's second largest city. In-service training on STI management for current pharmacists has been undertaken with the Ghana Pharmaceutical Society, which already undertakes this role with responsibilities for organising continuing education workshops and programmes.

All key policy and practice stakeholders were included in this research from its inception and gave their input on the design of the study, the implementation and analysis. This built trust and ownership of the research findings and made follow-up and scale-up far more likely. The public health implications of the research – namely that with proper training pharmacists *can* safely treat a range of STIs – were ensured of adequate communication by the involvement of STI experts from the MoH as well as the professional bodies representing Pharmacists.

Between 1997 and 1999, the intensification of STI management in approximately a hundred health facilities and the organisation of training/information sessions to reach more than 1,800 pharmacists and chemical sellers have contributed to a wider use of effective drugs against STI. According to O Bruce, the main factor that enabled the study findings to be applied in practice was the easy access to pharmacists by patients.

### ***Policy***

The study findings helped inform MoH policy to support training of pharmacists in treatment of STIs.

### ***Programme***

One of the most exciting outcomes of the programme according to Dr. Khonde was the adoption and use of the new STI molecules. Sustainability of the programme through the training of final year pharmacy students is another key outcome.

In the area of training of pharmacists in the effective management of STIs, WAPCAS confirms that almost all practicing pharmacists in the country have been reached. The last training sessions for pharmacists took place in the Western Region in March 2000.

### ***Practice***

Another outcome of the study since scale up of activities is that screening and detection of HIV/AIDS was made possible. Pharmacists, according to O Bruce, have now acquired a syndromic approach to treatment of STIs. As a result of application of the study recommendations there has been an improvement in counselling skills and partner tracing within the pharmaceutical community.

Another study will be necessary to assess the volume of STI patients still going to pharmacists for treatment and the quality of this treatment.

Further scale-up has begun; the extent to which it continues depends partly on political will from both the professions, resources available, a resolution of legal ambiguities, and commitment to collaborate on regulation. These areas were beyond the mandate of the project, but as with any project that seeks to make a lasting difference, a greater period of follow-up to promote scale-up, incorporation of training modules into pharmacy curricula and collaboration in development of formal regulatory mechanisms, perhaps should have been included if the MoH and pharmacy bodies wished it. However, at some point the initiative must rest with the country partners.

The long-term implementation of the results of this study requires that the training schedules developed be regularly updated to reflect changing STI epidemiology, and evolving drug regimens. The training schedules also need to be incorporated into national pharmacy training curricula and the MoH must clarify the legal boundaries for pharmacists' treatment of STIs and guidelines on when to refer.

Bringing the medical and pharmacy professions together to collaborate at all stages of this project was a big step forward and the project could not have worked if either had not been willing to participate. Whether such collaboration continues outside the framework of this project and this particular intervention remains to be seen, but the seeds have been sown and it is up to the country institutions themselves to build on success.

### ***Communication***

A liaison bulletin on current information on STIs has been developed and included in the Journal of the Pharmaceutical Society, which is published quarterly.

Pharmacists were the first to incorporate the Course on the Management of STIs in the curriculum of the School of Pharmacy. Before the end of the training programme, WAPCAS supported the Ghana Pharmaceutical Society to produce a 4-page bulletin on STIs in the Ghana Pharmaceutical Journal (first bulletin in Vol.21 Nos. 1& 2 March/June 1999). The first bulletin contained an article on the "Evaluation of the quality of treatment of urethral discharge and genital ulcers offered by community pharmacists in Accra and Tema in 1998" (WAPCAS). In the same, STD Manager, Joyce Addo Atuah wrote on "STD



Management training for Pharmacists". Joyce was then working as a pharmacist at the Police Hospital; she facilitated the training programme as a trainer. Posters have also been produced which have been displayed in pharmacies.

## **PUBLICATIONS**

1. Mayhew S. et al. (2001) 'Pharmacists' role in managing sexually transmitted infections: policy issues and options for Ghana.' *Health Policy and Planning* 16(2):152-160.
2. The Health Research Unit, Ministry of Health, Ghana; for the West Africa Project to Combat AIDS and the Centre de Recherche clinique du Centre Universitaire de Santé de l'Estrie (Sept 1996) 'Pharmacy Outlets survey: STD Management'.
3. Pepin J, Khonde N. West Africa Project to Combat AIDS (Dec 1998) 'Evaluation of the quality of treatment of urethral discharge and of genital ulcers offered by pharmacists of Accra and Tema'.
4. Joyce Addo-Atua and K. Nzambi. Syndromic management of STD in Ghana. A new dimension. Abstract presented at the XIIth International AIDS Conference, Geneva, 1998. (Abstract No 22204)

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Strategies for managing the dual risks of unwanted pregnancy and sexually transmitted infections among adolescents in rural Kenya

Factors	Pre-research	Research	Post-research	Scale-up Activities	Application/Utilisation
<b>Research Process</b>	<ul style="list-style-type: none"> <li>Research question dictated by country needs but research developed in response to donor call for proposals.</li> <li>WHO funded research</li> <li>Permission obtained from the Ministry of Education, Science and Technology and the District Commissioner</li> <li>Approval from District Education Officer</li> <li>Ethical approval from Kenyatta National Hospital Ethical Review Committee</li> </ul>	<ul style="list-style-type: none"> <li>Qualitative and quantitative methods used</li> <li>Local researchers used from University of Nairobi</li> <li>Ethical protocol adhered to throughout the study</li> </ul>	<ul style="list-style-type: none"> <li>Local workshop held with respondents and stakeholders to finalise the results.</li> </ul>		<b>Evidence Base</b> <ul style="list-style-type: none"> <li>4 papers have been published</li> <li>International and national conference presentations</li> <li>Lectures and seminars</li> </ul>
<b>Stakeholder involvement</b>	<b>Stakeholders:</b> respondents, school teachers (primary and secondary), parents and religious leaders, government ministries, mass media, university staff, local and international NGOs and local communities. <b>PRE-RESEARCH:</b> Approval for study obtained from all government stakeholders <b>POST-RESEARCH:</b> Results shared with all groups				<b>Policy</b> <ul style="list-style-type: none"> <li>University of Nairobi HIV/AIDS policy developed</li> </ul>
<b>Communication</b>	<b>POST-RESEARCH:</b> Local and national workshop held to disseminate findings				<b>Practice</b> <ul style="list-style-type: none"> <li>AMREF used the results to inform their adolescent reproductive health project</li> </ul>
<b>Macro Contextual factors</b>	Socio-politically and religiously polarised context of adolescent reproductive health in Kenya				

## **Strategies for managing the dual risks of unwanted pregnancy and sexually transmitted infections among adolescents in rural Kenya**

### **Description of Research**

This study attempted to explore the ways in which adolescent females and males (aged 10-19 years) understand, perceive and deal with the twin risks of unwanted pregnancy and sexually transmitted infections including HIV. This followed a realisation that there was limited knowledge on how Kenyan adolescents, who comprise about 60 percent of the country's population, deal with these risks. The study, which was conducted in Wote Division of Makueni District of Eastern Province, Kenya was conducted in three phases. In phase 1, 18 focus group discussions were conducted to explore the sexual and reproductive health sub-culture of adolescents; in phase 2, a community based survey was carried out with 790 adolescents to assess personal socio-demographic characteristics, sexual behaviours, and risk perceptions and strategies used to deal with dual risks; in phase 3, 42 in-depth interviews were held with respondents identified from the survey who manifest "high" and "low" risk behaviours. The study found *inter-alia* that both male and female adolescents experience difficulties in communicating about sexual matters and contraception with sexual partners. Rural based adolescents also have limited access to contraception and tend to be afraid of seeking condoms in public for fear of disclosure and reproach. Female adolescents also face difficulties in reconciling the desire for condom use, particularly when the risks of unwanted pregnancy and STIs/HIV infection are apparent, with local norms demanding submissiveness and lack of assertiveness in contraceptive decision-making.

### **Research Process**

#### ***Pre-Research Stage***

The Principal Investigator (PI), based at the University of Nairobi, Kenya developed the original research idea in response to a WHO research initiative that focused on a range of adolescent reproductive health research topics. The final choice of the topic had to be dictated by country specific needs. In the researcher's case, he realized that pregnancy rates and STI/HIV infections were on the increase among adolescents in Kenya and little information existed on how these adolescents perceive and deal with these risks. Data from the Kenya Demographic and Health Survey was particularly useful in identifying information gaps. Local studies based on student projects, theses and dissertations were also useful in indicating the needs for a study on the way adolescents perceive risks of HIV/AIDS and unwanted pregnancy.

Before the initiation of the research process, permission had to be obtained from the Ministry of Education, Science and Technology in Nairobi. This required the presentation of the study protocol to the Ministry for review and approval. Further permission was also sought from the District Commissioner who is the key government gatekeeper at the District level. Permission also had to be obtained from the District Education Officer so as to visit educational institutions in the district. These activities raised the profile of the study. Upon completion of the study, these same officials and other stakeholders such as school heads were invited to share in the results of the study.

At the national level, the legal system demands that all researchers present their research protocol to the Office of the President for approval. The researcher is further required to present himself/herself to the government representative at the local level (District Commissioner level) to be granted permission to operate in the local area of study. The researcher has also to present himself/herself to the officer in-charge of the relevant Ministry (District Education Officer) to get a letter of introduction to all educational institutions. While the process is rather long and cumbersome, it does ensure that key players in the policy decision-making process get to be involved either directly or indirectly in the research process. In this case, key politicians such as the local Member of Parliament and other civic leaders also

knew the Principal Investigator personally. The Principal Investigator was also well known to the local government officials after having worked with them on a number of projects in the District.

### ***Post-Research***

A local workshop was conducted at the study site to obtain the feedback of the respondents and to help distil and refine the final results of the study. The local participants included selected respondents in the study, schoolteachers, parents, local civic and administrative leaders, and representatives of local NGOs. The aim of the local workshop was to authenticate and validate the results of the study through feedback from the respondents and other local stakeholders, and also provide an opportunity for the researchers to provide their insights and interpretations of their findings. The feedback from these two sides greatly enhanced and enriched the quality of the final report with theoretical insights and experiential knowledge from the workshop participants. Limitation in resources to organise a longer workshop meant that only a few people could be invited to the workshop and this limited the level of participation. Lack of resources also pressured the PI into holding plenary sessions, which had the undesirable effect of limiting the participation of young people (respondents) as they shied from discussing certain sensitive issues in the presence of adults.

The quality of the published research results further attracted interest from academics, researchers and other organisations. The PI has had to mail copies of the published papers to many organisations on request and also give public lectures on invitation based on people having read the results of the study.

Several audience target groups were identified. First, the respondents were identified as key audience for the findings of this study. Schoolteachers (primary and secondary schools), parents and religious leaders were also seen as another audience. Other stakeholders identified include officials from the Ministries of: Education, Science and Technology, Gender, Culture and Social Services and Health and the mass media; academic staff and staff of the University of Nairobi; local NGOs in Kenya who took an interest in the results of this study such as the African Medical Research Foundation (AMREF). Among all these audiences, there was a striking interest in the results of this study.

### **Communication**

One local workshop and one national workshop were conducted to disseminate the results of the study. The local workshop conducted in Wote Town (study site) brought together selected adolescents who had participated in the research, teachers, local non-governmental organisations, the local administration, church leaders including the local Member of Parliament. These were individuals or organisations considered to be stakeholders in adolescent reproductive health. This workshop also served to validate the results of the study and to feed back the results to the community. The research team made oral presentations that were followed by discussions. The national workshop was conducted at the University of Nairobi and brought together academics, researchers and scholars from University of Nairobi, Egerton University and Kenyatta University, senior government officers from the Ministries of Education, Science and Technology, culture and Social Services, representatives of NGOs and clergy members. The Principal Investigator made most of the presentations, which were followed by discussions.

In future, the researchers believe that the process of dissemination of results should be given more attention and be in-built through the entire research process. It is intended to have the media cover every activity, starting right from the protocol through the visit to the district officials up to the dissemination. It is intended that the cost for this be factored into the research budget since the research team have found that good publicity generates public debate, interest in the research and the outputs can easily be fed into policy and programmes. There is also a need to make periodic appearances on the local TV and FM stations to publicise the work. While workshops and publications can in themselves be good tools of communication, their coverage tends to be quite limited, hence the need for using more informal channels of communication.

The researchers noted that senior politicians and government officials tend to delegate attendance of dissemination workshops to low ranking officers particularly when such workshops are held in the universities or at inexpensive hotels. Journalists also demand some consideration to give such workshops a favourable coverage. Donors need to make adequate financial provision for the dissemination of the research results. If possible, such dissemination workshops should be held in exclusive holiday sites as they tend to attract better attendance.

### **Scale up/Application**

#### ***Evidence base***

Four papers have since been published - one in *Reproductive Health Matters*, the second in *African Journal of Reproductive Health*, and a third in *Culture, Health and Sexuality* on the perspectives of adolescent boys on the risks of unwanted pregnancy and sexually transmitted infections; the ways in which both male and female adolescents deal with the risks of unwanted pregnancy and infection, and on the way female adolescents deal with the risks of unwanted pregnancy and STIs/HIV/AIDS, respectively. The fourth paper, which appeared as a WHO publication, looked at obstacles to managing the dual risks of unwanted pregnancy and sexually transmitted infections among young males in Kenya. Another paper is being considered for publication in an international journal.

Presentations of the study results have also been made in national and international conferences. The Principal Investigator has made presentations based on the results of the study at workshops held in Barcelona (Spain), Bangkok (Thailand), Pretoria (South Africa), University of Johannesburg (South Africa), and Madrid (Spain). Other findings have been made available through teaching, lectures, and seminars within the University of Nairobi and other local learning institutions.

#### ***Policy***

The results were used to inform the development of the University of Nairobi HIV/AIDS Policy, and the Principal Investigator was invited to the policy formulation Workshop.

#### ***Programmes***

AMREF wrote to the research team, requesting copies of the study's publications so that the findings could feed into an adolescent reproductive health project they are initiating in Wote (research site).

### **PUBLICATIONS**

1. C. Nzioka (2001) Dealing with the risks of unwanted pregnancy and sexually transmitted infections among adolescents in Kenya *African Journal of Reproductive Health* 5 (3): 128 - 144
2. C. Nzioka (2001) Obstacles to Managing the Dual risks of Unwanted Pregnancy and Sexually Transmitted Infections among Young Males in Kenya in WHO/UNAIDS (Eds) *The Health and Development of African Male Adolescents and Young Men*. Geneva: WHO/UNAIDS
3. C. Nzioka (2001) Perspectives of adolescent boys on the risks of unwanted pregnancy and sexually transmitted infections: Kenya *Reproductive Health Matters* 9 (17): 108 – 117
4. C. Nzioka (2003) Unwanted pregnancy and sexually transmitted infection among young women in Rural Kenya *Culture, Health and Sexuality* 6 (1): 31-44

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### Creating Linkages between Treatment for Incomplete Abortion Treatment and Family Planning – What Works Best in Kenya?

Factors	Pre-research	Research	Post-research	Scale-up Activities	Application/Utilisation
<b>Research Process</b>	<ul style="list-style-type: none"> <li>Study very relevant given maternal mortality and morbidity levels in Kenya</li> <li>Developed in consultation with all partners</li> <li>Funded by USAID</li> </ul>	<ul style="list-style-type: none"> <li>Study conducted in six public hospitals</li> <li>Staff at the hospitals participated in the study</li> </ul>	<ul style="list-style-type: none"> <li>National workshop and meetings held to discuss findings</li> <li>Findings and recommendations accepted by stakeholders</li> <li>Recommended that Model 1 be used by MoH when it introduces PAC services in other hospitals</li> </ul>	<ul style="list-style-type: none"> <li>3-Year national plan of action drawn up to scale up PAC services</li> </ul>	<p><b>Evidence Base</b></p> <ul style="list-style-type: none"> <li>Results provided evidence base for national PAC curriculum</li> <li>Results cited in Kenya National Reproductive Health Training Plan (2000-04)</li> </ul> <p><b>Advocacy</b></p> <ul style="list-style-type: none"> <li>PAC Working Group advocating to have MVA kits included in MoH essential supplies list.</li> </ul> <p><b>Policy</b></p> <ul style="list-style-type: none"> <li>National PAC curriculum launched in 2003 based on recommendations</li> <li>MoH authorised training of Clinical Officers and public nurse-midwives in PAC.</li> </ul> <p><b>Programmes</b></p> <ul style="list-style-type: none"> <li>Several technical assistance agencies supporting various PAC initiatives eg. Prime II Project, EngenderHealth.</li> <li>Training programmes to equip clinical officers and nurse midwives with MVA skills</li> <li>Increased funding to MoH Safe Motherhood Programmes</li> </ul> <p><b>Practice</b></p> <ul style="list-style-type: none"> <li>More organised and systematic PAC services provided in hospitals</li> <li>Fledgling PAC services strengthened – dedicated MVA and PAFP team.</li> </ul>
<b>Stakeholder involvement</b>	<p><b>Stakeholders:</b> MoH, Population Council, IPAS, hospital staff</p> <p><b>PRE-RESEARCH:</b> MoH selected study sites based on discussions with partners and stakeholders</p> <p><b>RESEARCH:</b> Consultations held to discuss problems, challenges and possible solutions</p> <p><b>POST-RESEARCH:</b> Findings discussed with stakeholders based on which recommendations made</p>				
<b>Communication</b>	<p><b>RESEARCH:</b> Hospital staff briefed on data collection progress. Briefing meetings with USAID and MoH at Division of Reproductive Health.</p> <p><b>POST-RESEARCH:</b> National workshop held to discuss findings and recommendations with stakeholders</p> <p>Follow-up meetings held with individual organisations.</p>				
<b>Macro Contextual factors</b>	<p>Abortion is illegal in Kenya but permitted if required in order to save the mother's life. Most abortions procured in risky settings.</p>				

## Creating Linkages between Treatment for Incomplete Abortion Treatment and Family Planning – What Works Best in Kenya?

### Description of Research

Complications arising from unsafely induced and spontaneous abortions still constitute a major proportion of maternal mortality and morbidity in Kenya. Maternal mortality in Kenya is estimated at 1000 per every 100,000 live births<sup>1</sup>; although accurate data on abortion-related deaths is not known, it is estimated that about one-third of maternal deaths is caused by abortion-related complications. Also, incomplete abortions constitute a significant proportion of gynaecological admissions. As a result, the Ministry of Health (MoH) and other interested organisations have paid much attention over the years to improving the emergency treatment of abortion complications, and to reducing the overall incidence of unsafe abortions. Besides improving the medical management of abortion-related complications, providing family planning counseling and offering services to women who have experienced an abortion is important so that they can avoid a mistimed pregnancy. It is important to note that abortion is illegal in Kenya unless it is necessary to save the life of the women and so most are clandestinely procured in risky settings.

In 1997, the Population Council, the Ministry of Health and Ipas carried out a study in Kenya to establish the most effective way of providing postabortion family planning (PAFP) information and services as part of a comprehensive PAC service. The study compared three different models of PAFP counselling and services, by introducing each model into two public hospitals. The models varied by where the service was provided and by whom.

Model 1: FP services provided on GYN ward by GYN ward staff (Coast General Hospital; New Nyanza General Hospital)

Model 2: FP services provided on GYN ward by MCH/FP clinic staff who would come to visit the PAC client before discharge (Nakuru General Hospital; Meru District Hospital)

Model 3: FP services provided at the MCH/FP clinic by clinic staff, after the PAC client had been discharged

The three models were evaluated after six months of implementation and Model 1 was found to be the most effective, the easiest to set up and most feasible in terms of logistics and patient flow. In addition, it was the most acceptable model by both clients and service providers.

### Research Process

#### *Pre-Research Stage*

This study was collaboration between Population Council, Ipas, USAID, and the Ministry of Health in Kenya. Although the Population Council was technically responsible for the research design, the study was developed in consultation with all the partners, and the MoH staff was actively involved in site selection. This process took the form of meetings and correspondence between the stakeholders.

#### *Research Stage*

Over the months the interventions took place, the field coordinator regularly held meetings with the hospital staff to brief them on the data collection progress. The study monitor at Population Council also held briefing meetings with the funding agency, and the MoH staff at the Division of Reproductive

<sup>1</sup> 2004 World Population Data Sheet, Population Reference Bureau

Health. Progress was reviewed and problems and challenges faced were discussed and solutions sought during these consultations.

### ***Post-Research Stage***

The study findings and recommendations were disseminated widely to stakeholders in Kenya through a national workshop and a series of follow-up meetings with individual organisations.

The recommendation was made that the MoH uses Model I as it introduces postabortion care (PAC) services into other hospitals around the country. Other recommendations included the following:

- Make PAC an integral and standard hospital service.
- Encourage on-the-job training in PAC so that services are sustainable in the case of staff turnover.
- Institute PAC into nurses and clinical officers' pre-service training.
- Include PAC equipment and supplies into the budgets for MoH hospitals and manual vacuum aspiration (MVA) kits into the MoH essential supplies list.
- With the consent of the client, involve their male partner in the PAC process.

### **Communication**

Focused Dissemination: In Meru, interviewees indicated that follow up meetings were organised at the hospital by the Matron and Gynaecologist to discuss the findings as both had been involved in the study. There were also reports of in-house follow-up meetings organised to discuss the study results in New Nyanza General, which were organised and presented by the then-nurse in the MVA room, who had attended the national dissemination meeting in Nairobi.

### **Scale-Up/Application**

#### ***Evidence Base***

The study findings formed the basis for developing a national PAC curriculum. The study results were also cited in the Kenya National Reproductive Health Training Plan for the year 2000-2004 as the basis for including integrated PAC training in the guidelines.

#### ***Policy***

The MoH started a process in 2000 to scale up PAC services throughout the country. A three-year national plan of action was drawn up, which included most of the study recommendations. The MoH has also authorised the training of Clinical Officers and public Nurse-midwives in PAC. A new national curriculum was launched in 2003 and the MoH issued guidelines recommending that all induced abortions under 12 weeks be treated on the gynaecological ward, and that the staff provide counseling on family planning. This was one of the recommendations from the 1997 study.

#### ***Advocacy***

Advocacy efforts have been initiated by the PAC Working Group to have the MVA kits included into the MoH essential supplies list, which every hospital has to procure.

#### ***Programmes***

Several technical assistance agencies in the country have been supporting various PAC initiatives. These include PRIME II Project, which ended in 2004, but which had spent considerable amount of resources building the capacity of private nurse midwives to provide PAC services. Other agencies that have been involved in PAC in the country include EngenderHealth (assisting the MoH to scale up PAC services; supporting PRIME II on supervision), Ipas (distribution of MVA kits and training), Kisumu Medical and



Educational Trust (KMET, promoting PAC services by private practitioners) and the AMKENI project (promoting PAC in public facilities in Western and Coast Province). All these agencies have consistently recommended in their PAC training and services that PAFP be offered on the ward by providers.

EngenderHealth's 'Amkeni' project has tried to strengthen all the PAC components in the public institutions that it supports, including providing PAFP through on-job training and facilitative supervision. Amkeni is now focusing on helping public hospitals create comprehensive Reproductive Health units in which women can receive care under one roof.

There are efforts currently underway to streamline the supply of MVA kits with the aim of having them included in the essential supplies list so that district and provincial level hospitals receive regular supplies. A PAC supervision checklist has been developed that includes PAFP.

Training programmes are underway to equip registered clinical officers and nurse midwives with MVA skills, to increase the numbers of staff that can offer the service, and to bring PAC service to health centers. So far, there are four hospitals where training has been held, and where these two cadres of staff can do MVA. The MoH's 'Safe Motherhood Project', implemented with support from the Population Council and funded by DFID, also trained providers from 15 facilities in Western Province in MVA and provided each of their facilities with an MVA kit. Although the project did not offer any direct assistance in facilitating PAFP, its Health Provider Manual, which is given to each project facility, emphasises that post abortion family planning is best offered where the MVA treatment is provided. There has been an expansion of the funding given to Safe Motherhood programmes in the MoH, which covers PAC, from its development partners, including SIDA and DFID.

In August 2002, FRONTIERS carried out a review to ascertain the extent to which the Operations Research recommendations had been adopted in the public sector. Two researchers visited each of the six study hospitals and at each site interviews were held with key informants including hospital administrators, heads of the gynaecological wards, the hospitals' chief gynaecologists, and PAC service providers. Interviews were also held with PAC programme managers at EngenderHealth, Intrah/PRIME II and the MOH. In addition, PAC and PAFP statistics for the last three years were obtained from each site.

Among the staff interviewed were 15 who were aware of the 1996/97 study, including 12 who had taken part in the study. When asked if they thought the study made any significant contribution to their hospital's PAC programme, the response was in general positive and the services appear to have been sustained. The study was seen to have pushed PAC higher up on the hospital's agenda, bringing possible solutions to an issue that the hospitals have long been grappling with. The study was credited with helping better organise the PAC services and making them more systematic. The study is also seen as having strengthened the fledgling PAC service in some of the hospitals, by introducing the idea of a separate facility away from the busy minor theatres, and by putting in place a dedicated MVA and PAFP team. The study was credited with securing hospital administration's support to the PAC service, which is evident through the institutionalised system for procuring MVA kits.

Two public hospitals that were not part of the study were also visited to see the PAFP model being applied. It was found that all six hospitals have continued to provide PAC services, and all of them have maintained a dedicated side room on the gynaecological ward where MVA treatment is given. The hospitals have also more or less streamlined the procurement of the MVA kits by purchasing them out of funds raised through cost sharing. There were differences, however, in the personnel providing MVA. Only in Nakuru Provincial General were nurse midwives providing MVA treatment; in the other sites, MVA treatment was carried out by doctors and clinical officers, with the nurse-midwives only providing assistance. The MoH has been looking at whether nurse midwives should be allowed to offer PAC services, and it is hoped that a policy will be issued soon.

Coast General Hospital has also supported the start-up of MVA and PAFP services in three district

hospitals within the province. Through the leadership of the hospital gynaecologist, who is also the Coast Province RH Coordinator, the staff have participated in training other staff at the district hospitals in MVA procedures, sensitised them on humane handling of abortion patients, and on the provision of PAFP. In each of these hospitals, MVA rooms have been set up and counselling is offered on ward after the procedure. The hospitals purchase the MVA kits out of money raised from cost sharing.

Moi University Teaching Hospital, Eldoret, has switched from Model 3 to Model 2, by offering PAFP on the gynaecological ward before discharge, but by an MCH/FP clinic nurse who comes to the ward daily. In Nyeri General (the other Model 3 site) the chief gynaecologist reported that sometimes, if the hospital shift allows, a FP nurse is posted to the gynaecological ward on a temporary basis to attend to PAC patients (i.e. Model 2). The routine procedure however is Model 3; the women are referred to the MCH/FP clinic for PAFP. The FP nurse from the MCH/FP clinic goes to the gynaecological ward and escorts all the PAC patients to the clinic, where they join others waiting for FP counselling and services.

Coast General is still using Model 1, although when the ward-based PAC nurse is on leave, the service is provided by a nurse seconded from the MCH/FP clinic. At New Nyanza, there were discrepancies in the information given by two of the key informants regarding PAFP methods and referral: while one maintained that clients are only counselled on the ward and referred to the FP clinic for method collection and follow-up, the other reported that a limited range of methods (pills, condoms, injectable) were offered on the ward, and that clients who were not ready to start a method were advised to come back in two weeks to the FP clinic.

Nakuru Provincial General and Meru District Hospitals have now switched from Model 2 to Model 1, with either the ward nurses or the MVA nurse providing the information and service on the ward.

This review has confirmed that involving the eventual users of a study's findings throughout the research study is critical. For example, at Coast General Hospital, the Chief Gynaecologist, who is also the Provincial Gynaecologist, was heavily involved in the study and has been at the hospital long enough to institute a successful PAC programme. To date, the activities started during the study have carried on, and the Gynaecologist has also spearheaded the expansion to other district hospitals, in her capacity as the regional RH coordinator.

The personal initiative of a hospital staff member who had an interest in PAC service and in the study appears to have played a role in bringing attention to the findings. For example, one of the gynaecologists at the Moi University Teaching Hospital in Eldoret personally organised meetings with the Medical Education Committee to have the results discussed in the hospital's continuing education programme. Although the hospital did not adopt the on-ward-by-ward-staff model in this particular institution, the gynaecologist was confident that it had changed staff attitudes to postabortion patients.

The staff interviewed felt that problems of staff shortage had been exacerbated by a reported government decision to stop employing new nurses; due to the shortage, the available nurses are expected to perform all ward duties. Consequently, those trained in PAC cannot give 'exclusive' care to postabortion patients, because they have to perform other gynaecological ward duties as well. In some facilities, the lack of physical space was also cited as another reason why exclusive PAC services are difficult to set up.

Sufficient refresher training for staff in PAFP, which is essential for the service to run effectively, is not provided. Most of the nurses originally trained in this study have since been transferred from the wards, or left the hospitals altogether. Coupled with reported staff shortages, this has caused a gap in continuity of the PAC/PAFP services.

Other reasons cited for the non-implementation of the research findings include lack of material and financial resources required. For instance the supply of MVA kits: In all hospitals, MVA procurement is handled through the centralised supplies system - wards submit their requirements and then wait for purchases made through the pooled revenue from cost sharing. Delivery of services is affected if the supplies are late or not given top priority by the purchasing department.

Infection control during MVA: The 1997 study had recommended on-site autoclaving, because this would solve the delays in giving PAC treatment which occur when the MVA equipment has to be sent away to the centralized autoclave services. All sites reported frequent lack of sterilizing services.

Inflexibility of existing hospital systems: This could also be the reason for non-utilisation of the recommendations in some of the hospitals. For example, the current FP commodities logistics system in government hospitals is organised so that FP supplies are given in one batch to MCH, all in one register kept under lock and key. Some hospitals find it difficult to keep two registers, one on the gynaecological ward, and the other on the MCH clinic. Reconciling two registers may be considered problematic and extra work for staff, which further increases the reluctance to send FP supplies to the gynaecological ward.

Secondly the hospitals system of shifts for deploying nursing staff can affect the gynaecological ward's likelihood of having a qualified PAFP service provider stationed there for any reasonable length of time. It was frequently pointed out that staff trained and experienced in PAFP had been recently transferred to another unit or were on leave, leaving the gynaecological ward to rely on staff from the MCH/FP clinic.

## **PUBLICATIONS**

1. Solo, J., Ominde A. et al. 1998. *Creating Linkages between Incomplete Abortion Treatment and Family Planning Services in Kenya: What Works Best?* Population Council: Nairobi, Kenya.
2. Solo, J., Billings, D. et al. 1999. .Creating Linkages between Incomplete Abortion Treatment and Family Planning Services in Kenya.. *Studies in Family Planning*, 30,1:17-27.

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**Improving the Management of STIs among MCH/FP Clients at the Nakuru Municipal Council Clinics, Kenya**

Factors	Pre-research	Research	Post-research	Scale-up Activities	Application/Utilisation
<b>Research Process</b>	<ul style="list-style-type: none"> <li>Study initiated by Population Council (PC)</li> <li>Designed by PC in consultation with Nakuru Municipal Council (NMC)</li> <li>Ethics standards approved by PC's internal review board</li> <li>Funded by USAID</li> </ul>	<ul style="list-style-type: none"> <li>Operations Research team included NMC Medical Officer of Health and his staff</li> <li>Study design most suitable for the purpose as confirmed by researcher and stakeholder</li> </ul>	<ul style="list-style-type: none"> <li>Data interpreted and recommendations drawn up with NMC staff</li> <li>Study addressed potential public health impact of implementing recommendations</li> </ul>	<ul style="list-style-type: none"> <li>NMC and UON trained 95% of clinic staff on client counselling and syndromic management (CIDA funded)</li> <li>Research team, MoH and National AIDS and STD Control programme (NAS COP) met to discuss application of findings</li> </ul>	<p><b>Evidence Base</b></p> <ul style="list-style-type: none"> <li>See Publications list</li> </ul> <p><b>Advocacy</b></p> <ul style="list-style-type: none"> <li>NMC used findings for internal advocacy</li> </ul> <p><b>Programmes</b></p> <ul style="list-style-type: none"> <li>Condom promotion is now included in client counselling and condoms offered to clients thought to have STIs.</li> <li>Public Health Technicians follow up partners of women with vaginal discharge from the details provided by the clients and encourage them to seek treatment.</li> <li>Municipal Council strengthened its public health promotion activities</li> </ul> <p>All the above are still being sustained.</p> <p><b>Practice</b></p> <ul style="list-style-type: none"> <li>Client counselling increased in the clinics. Partner notification has also been strengthened throughout the clinics, especially in the case of married women.</li> <li>More nursing staff using syndromic management flowcharts</li> <li>Increased focus on counselling of clients diagnosed as having STIs</li> <li>Condom promotion included in client counselling; condoms offered to clients if thought to have STIs.</li> </ul> <p>The above are still being sustained.</p>
<b>Stakeholder involvement</b>	<p><b>Initial Stakeholders:</b> CIDA, NMC, MoH and health facility clients.  <b>Additional Stakeholders for Dissemination:</b> The donor community and other organisations implementing RH programmes in Kenya.  <b>PRE-RESEARCH:</b> Study designed by PC in consultation with NMC and University of Nairobi (UON).  <b>RESEARCH:</b> NMC and MoH were involved in an advisory role, and also participated as trainers of the fieldwork team.  <b>POST-RESEARCH:</b> Findings discussed with MoH and NASCOP to identify ways forward</p>				
<b>Communication</b>	<p><b>RESEARCH:</b> Weekly briefings given to the NMC and MoH teams by research coordinator.  <b>POST-RESEARCH:</b> Two dissemination workshops held with stakeholders and broader audience. Follow-up discussions held with NASCOP and the MoH.                      A written report and two-page summary produced and disseminated; dissemination by NMC and PC</p>				

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## **Improving the Management of STIs among MCH/FP Clients at the Nakuru Municipal Council Clinics, Kenya**

### **Description of Research**

The integration of services for preventing and managing sexually transmitted infections (STIs) with maternal, child health and family planning (MCH/FP) services has been strongly promoted in sub-Saharan Africa following the International Conference on Population and Development in 1994. Kenya's public health policy guidelines prescribe a standard integrated package of services for MCH/FP clients, which includes screening, diagnosis and treatment for STIs. The Nakuru Municipal Council (NMC), located in the Great Rift Valley in Kenya, has been running integrated services in five MCH/FP units since 1988, and was selected for a seven-year CIDA-funded project to strengthen STI services, implemented by Universities of Nairobi and Manitoba, Canada (UON/Manitoba). In 1995, the Africa OR/TA II Project<sup>2</sup> carried out a case study<sup>3</sup> of the integration of STI/HIV services in the clinics, and in 1998 conducted a study<sup>4</sup> to test the effectiveness of improved approaches to handling STIs amongst the antenatal and FP clients. Findings revealed that RTIs, and specifically STIs, are common in family planning (FP) and antenatal care (ANC) clients. Also it was found that using a standardised checklist leads to high levels of women being informed about STI symptoms and complications, and about dual protection.

### **Research Process**

#### *Pre-Research Stage*

The idea for the study was initiated by Population Council, who discussed it with the UON/Manitoba STD Project Director. They then collectively approached the NMC to discuss further details. The study was designed by the Population Council in consultation with the NMC's Medical Officer of Health and several of his staff. Population Council selected the Nakuru site because it was one of the first programmes in Kenya to integrate STI and MCH services. It was also a follow-up to a case study on integration carried out earlier by the Population Council. According to W Kariba, the Public Health Officer at the NMC during the study, the NMC viewed the study as a priority as it had previously integrated STI and MCH/FP services and now needed an independent study to assess how well they were performing compared to the previous system. Although Population Council designed the study, staff from FHI and the University of Nairobi provided input on questions regarding integration, syndromic management, and risk assessment. The study design was approved by the project management board at Population Council, and was one that could be replicated elsewhere. Ethics standards for the study were reviewed and approved by Population Council's internal review board and were adhered to throughout the study.

Stakeholders for the study were Population Council, CIDA, NMC, and health facility clients. The primary target for Population Council was the NMC who would use the results as well as the Ministry of Health (MoH), Kenya. As far as the NMC was concerned, the target audience were ANC mothers attending the NMC's Maternal and Child Nutrition (MCN) clinics.

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<sup>2</sup> Africa Operations Research and Technical Assistance Project II is a USAID funded project; sub-agreement with Population Council.

<sup>3</sup> Kariba, James Wabaru, Bedan K Kariuki et al. 1997. Integration of STI and HIV/AIDS with MCH/FP Services: A Case Study of Nakuru Municipal Council's Project on Strengthening STD/AIDS Control, Population Council: Nairobi, Kenya.

<sup>4</sup> Solo, Julie, Ndugga Maggwa et al. 1999. *Improving the Management of STIs among MCH/FP Clients at the Nakuru Municipal Council Health Clinic*, Population Council: Nairobi, Kenya.

### ***Research Stage***

The study team included the NMC Medical Officer of Health and some of his staff. They also provided technical and logistical support throughout the entire project. Staff from the Microbiology Department at the University of Nairobi was involved in the laboratory testing.

Weekly briefings were made by the Population Council research co-ordinator to the NMC and MoH partners about the study's progress. Participating clients in the NMC health facilities were also well briefed and allowed to discuss and respond to arising issues. These briefings were provided verbally.

The partners were instrumental in helping sort out logistical problems that would have affected the quality of the study, for instance, refusal by nursing staff to implement the intervention, which was resolved after the NMC and MoH stepped in.

### ***Post-Research Stage***

A meeting was held with the NMC health team to analyse and interpret the data and develop recommendations. This was followed by two dissemination workshops at Nairobi and Nakuru, organised with the assistance of the NMC, at which the findings were discussed. The workshops were attended by MoH Programme Managers, the donor community, and organisations implementing RH programmes in Kenya. During these workshops, service providers and programme managers supported continued use of the syndromic management algorithms until improved diagnosis and treatment protocols were introduced in the country. They also recommended that service providers should focus more on counselling, condom promotion and education on STIs to promote preventative behaviours, and that use of the checklist be continued. This was followed by separate discussions with the MoH and National AIDS and STDs Control Programme (NAS COP) to see how the findings could be applied to the national programmes and to discuss the practical aspects of implementing the findings. Public health implications of the study were also communicated to the policymakers at these meetings.

The NMC found the findings easy to interpret but felt that consultancy in supervision while implementing the recommendations was necessary. W Kariba of the NMC feels that the findings should have been released more quickly in order to be able to produce better outcomes. The NMC admitted that while the research team did address the public health implications of the study, the NMC was unable to act on these as it was already in a financial crisis.

In addition to the above, a written report and two-page summary were produced and distributed widely, though NMC Health Department staff who were interviewed later regarding the utilisation of the study results informed the interviewers that they had seen the written report only once in the MoH office. W Kariba states that this was due to a limited budget, which made wider dissemination of the report more difficult. Also there was high staff turnover and many of the Population Council staff who were involved in the study, left the organisation shortly after the dissemination activities.

### ***Scale-Up/Application***

With the ending of the Africa OR/TA Project II, no support or technical assistance could be provided to the Municipal Council to move the recommendations into action. Others at Population Council also became involved in other activities such as starting up FRONTIERS and so no one was available in the follow-up stage to assist in the utilisation of the findings.

While there was no provision in the original research budget for scale up of activities, Population Council carried out a subsequent study to assess how well the NMC utilised available resources eg. on

management of time. This provided NMC with the opportunity to address basic clinic management issues and staff output.

The NMC Health Department did not appear to have any new policy decisions or reviews on the management of STI cases in the clinic population since the study. However, W Kariba confirms that the Municipal Council's Public Health Department together with the University of Nairobi's STI Project trained 95% of clinic staff on both client counselling and syndromic management, funded by CIDA. UON manuals were used for this. It has also been supplying STI drugs.

### ***Programmes***

The Municipal Council's Chief Public Health Officer who was a key participant in the study, retired soon after the study ended and the Medical Officer of Health was transferred out of the Council at the same time. If they had ~~been there~~remained in post, there may have been more discussions on how the results could be utilised. In addition, the Population Council staff also moved on to new projects.

The Municipal Council did not provide any guidelines or instructions on how to continue using the risk assessment checklist or how to incorporate it in the client counselling session. The checklist was also not made available to service providers after the study ended.

The Municipal Council has since strengthened its public health promotion activities, including STI/HIV prevention messages, reactivated partly due to the IMPACT project<sup>5</sup> and the Council's concern over the growing HIV/AIDS problem within the Municipality. Teams of Public Health Officers visit selected regions of the town on a weekly basis to provide information to the public at various venues.

### ***Practice***

The review found that the Municipal Council and other public sector clinics had a shortage of STI drugs and test reagents. As a result some clients had to buy the drugs from private pharmacies at commercial prices.

Even staff who were involved in the study and dissemination workshop were unable to recall the recommendations of the study, four years later, primarily because they had no access to the study report and had seen it only once in the MoH's office. There were also no in-house meetings to discuss the results or any activities towards their utilisation.

Only the nurses directly involved in the study were aware of the checklist and risk assessment questions used to screen clients for STI risk, but these were not used in any of the facilities. Despite it being a Council policy, pelvic examinations or simply visual examinations were not done because the clinics did not have electricity or supplies for sterilising equipment. Even basic supplies such as gloves and disinfectants were not available for routine client examinations.

While all the Municipal clinics had a laboratory technician and facilities for syphilis and routine testing, all samples were sent to Langa Langa Clinic as it was the only one with reagents and urinalysis tests. Both ANC and FP clients were referred to the Provincial General Hospital for HIV testing.

Despite these shortcomings, more nursing staff have been found to be using the syndromic management flowcharts in diagnosing and treating STI clients.

One of the big issues with this study is that syndromic management was not found to be very effective in the MCH/FP setting, and yet, even when presented with this information, NMC staff felt they had to do something, particularly given the high prevalence of STIs, and because they had limited other options.

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<sup>5</sup> USAID's global HIV/AIDS prevention and care project implemented by FHI

Despite hearing the findings, they were resistant to acting upon them because they had no good alternatives. The lead researcher at Population Council believes that the work in Nakuru and elsewhere on syndromic management is interesting because it shows that effectiveness studies are needed before widespread introduction of a practice—once people started practising syndromic management, even when shown that it was not particularly effective for this population, they were resistant to discontinuing it.

UON subsequently continued with activities through the FHI IMPACT project, under which an evaluation was carried out. On being satisfied that the services had attained high standards, funding for clinical services in NMC were withdrawn as confirmed by W Kariba.

## **PUBLICATIONS**

1. Solo, Julie, Ndugga Maggwa et al. 1999. *Improving the Management of STIs among MCH/FP Clients at the Nakuru Municipal Council Health Clinic*, Population Council: Nairobi, Kenya.
2. Kariba, James Wabaru, Bedan K Kariuki et al. 1997. *Integration of STI and HIV/AIDS with MCH/FP Services: A Case Study of Nakuru Municipal Council's Project on Strengthening STD/AIDS Control*, Population Council: Nairobi, Kenya.
3. FRONTIERS Utilisation Case Studies No. 2: *Improving the Management of STIs among MCH/FP Clients at the Nakuru Municipal Council Clinics, Kenya*. 2002. Population Council.

## **Contributors**

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**Enhancing the continuum of care of HIV/AIDS infected and affected patients in resource constrained settings in KwaZulu-Natal, South Africa:  
Getting Research into Policy and Practice**

Factors	Pre-research	Research	Post-research	Scale-up Activities	Application/Utilisation
<b>Research Process</b>	<ul style="list-style-type: none"> <li>Seed funding</li> <li>Study backed by HAI with approval from UNAIDS, WHO and FHI.</li> <li>Credibility of study and team amongst study population established through community liaison</li> <li>Ethics approval from Nelson R Mandela School of Medicine Research Ethics Committee</li> </ul>	<ul style="list-style-type: none"> <li>Operational Research conducted using design that could be replicated in other settings</li> <li>Core group managing research team met on weekly/monthly basis to assess progress</li> </ul>	<ul style="list-style-type: none"> <li>Findings used to draw up policy recommendations with the help of DoH, academia, NGOs and PLWA.</li> <li>Team responded immediately to priorities identified</li> <li>Dissemination was timely for implementation for stakeholders and team members</li> </ul>	<ul style="list-style-type: none"> <li>Comprehensive course on HIV held for 1000 delegates, which included doctors, nurses and managers, who in turn signed contracts to train 30 health professionals in their institutions</li> <li>Scale up ideas developed through stakeholder consultations, based on research results</li> <li>Funding obtained from GFATM for scale up of comprehensive package of prevention, treatment, care and support</li> </ul>	<p><b>Evidence Base</b></p> <ul style="list-style-type: none"> <li>Research provided evidence for advocacy and scale up of activities</li> </ul>
<b>Stakeholder involvement</b>	<p><b>Stakeholders:</b> Dept of Medicine, University of Natal; Provincial AIDS Action Unit; South Coast Hospice; Nkonjeni Hospital; Grey's and Edendale Hospitals; Kwadabeka Primary Health Clinic; KEH Hospital; National Association for PLWA; Church of Scotland Hospital; Women's Law Project; PAAU; pMTCT Directorate; Durban Chamber of Commerce and Industries</p> <ul style="list-style-type: none"> <li>Collaborative partnership with Dept of Health, KwaZulu-Natal, private sector and NGO/CBO groups</li> <li>All stakeholders involved in development of tools and facilitating research process</li> <li>Partners shared ideas and resources, and provided mentorship.</li> </ul>				<p><b>Advocacy</b></p> <ul style="list-style-type: none"> <li>Findings used to advocate for provision of ARV in S Africa in era of anti-retroviral policies.</li> <li>Advocacy on ARVs and treatment for patients with HIV, targeting all communities infected and affected by HIV.</li> </ul>
<b>Communication</b>	<p>Communication strategy jointly decided.</p> <p><b>RESEARCH:</b></p> <ul style="list-style-type: none"> <li>Computer linkages between 6 ECI KZN sites.</li> <li>Close working relationships between the groups eg. team building exercises and social functions to develop skills and bridge relationships.</li> <li>ECI KZN Committee meetings every 3 months.</li> </ul> <p><b>POST-RESEARCH:</b></p> <ul style="list-style-type: none"> <li>Results presented at conferences and research forums.</li> <li>Fact sheets made available to the media</li> <li>Facts sheets and research reports posted to e-Groups and websites</li> </ul>				<p><b>Policy</b></p> <ul style="list-style-type: none"> <li>Provincial health plans developed based on findings</li> </ul>
<b>Macro Contextual factors</b>	<ul style="list-style-type: none"> <li>Political situation with respect to S Africa's national strategic plan for HIV/AIDS, created uncertainty with respect to antiretroviral availability and cost implications of their provision</li> <li>There was a lack of clear policy on internationally accepted best standards of care, e.g. MTCT</li> </ul>				<p><b>Programmes</b></p> <ul style="list-style-type: none"> <li>GFATM reached KZN</li> <li>NGO and ARV training-related programmes developed</li> <li>Several home-based care programmes established in the district</li> </ul> <p><b>Practice</b></p> <ul style="list-style-type: none"> <li>GFATM funding has directly and indirectly facilitated the provision of antiretrovirals to over 10,000 patients in KwaZulu-Natal by end April 2005, and the care of over 60,000 patients known to be infected by HIV/AIDS.</li> </ul>



## **Enhancing the continuum of care of HIV/AIDS infected and affected patients in resource constrained settings in KwaZulu-Natal, South Africa: Getting Research into Policy and Practice**

### **Description of Research**

In 1998, a team from the Harvard School of Public Health's AIDS Institute (HAI), the Enhancing Care Initiative (ECI)<sup>6</sup>, performed site visits to South Africa to identify a multi-sectoral team that could examine and address deficiencies in HIV/AIDS prevention, treatment, support and care in resource constrained settings. The HAI provided seed funding to Enhancing Care Initiative, KwaZulu-Natal. Key partners, namely academia, government, and NGO/CBO representatives were selected that could address key areas of need in HIV/AIDS in KwaZulu-Natal, one of South Africa's worst affected provinces. The team's objectives were to examine deficiencies in HIV care in broad terms, along with case management and cost-effective care strategies.

The Enhancing Care Initiative, KwaZulu-Natal, a consortium of partners (see stakeholders list in framework), were expected to review the quality of care in specific home, community, workplace and hospital settings in KZN from the perspectives of both providers and clients. Operational research was implemented to identify priority needs in terms of the 10 areas of care (VCT; basic medical services; laboratory and diagnostic services; HIV/AIDS Clinical Management; Antiretroviral Therapy and new therapies; Community-Based Care; Social Services; Care Education and Information Dissemination; Supportive and Care of the Dying; Care of the carer) and rapidly translate into policy and practice. The results of these needs and priorities were translated into provincial health plans, which involved the scale up of successful pilot programmes throughout the whole province. An innovative collaborative proposal, involving substantial commitments from the local private sector, was sent to the Global Fund to fight AIDS, Tuberculosis and Malaria, and was awarded a grant of USD 72 million for the scale up of a comprehensive package of prevention, treatment, care and support, including antiretrovirals. The study was conducted between 2000 and 2002.

### **Research Process**

#### *Pre-Research Stage*

The Nelson R. Mandela School of Medicine, based at the University of Natal, in KwaZulu-Natal, South Africa, (now called the University of KwaZulu-Natal), in collaboration with the HAI, formed a partnership with the Department of Health, KwaZulu-Natal, the private sector and various NGO/CBO groups (including people living with HIV/AIDS) that were involved in HIV/AIDS prevention, treatment, care and support. The selection of partners was done by site visits and consults with various stakeholders and communities.

During Phase I the ECI KZN team steering committee, constituting a core team of representatives from the Nelson R. Mandela School of Medicine, together with the HAI, brought all key stakeholders together and identified the key issues in HIV/AIDS prevention, treatment, care and support at the 6 research sites throughout KwaZulu-Natal (King Edward Hospital, Grey's and Edendale Hospital, Nkonjeni Hospital (Ulundi), Church of Scotland Hospital (Tugela Ferry), Kwadabeka Clinic and South Coast Hospice. Additional sites include McCord's Hospital Sinikethemba Clinic, Warwick Triangle EAP Centre and Chest Clinic.). These sites represented urban and rural communities, as well as all tiers of health services in the South Africa health care system (district, regional and tertiary), as well as non-governmental organisations. A situational analysis of these 6 research sites developed research tools to understand the needs of patients and providers in the public and private sector in HIV/AIDS.

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<sup>6</sup> ECI established by Harvard University and Merck Company Foundation in 1998 to improve clinical care of people living with HIV and AIDS in resource-constrained settings.

The target study population was patients living with HIV/AIDS at the research sites, health workers, stakeholders and policy makers involved in prevention, care, treatment and support of patients infected and affected with HIV/AIDS. The ECI KZN team members were involved in choosing the target audiences at their sites. The study results were aimed at stakeholders involved in the prevention, treatment, care and support of patients living with HIV/AIDS in resource-constrained settings.

The study was highly relevant from the NGO perspective. In the case of South Coast Hospice, which has been in existence since 1983, it was quite important to evaluate the perceptions of the community/recipients of the programme that it provided services to, especially when compared to areas where such services were non-existent.

The Clinical Manager of South Coast Hospice, who participated in the study, confirms that ethical protocols were adhered to throughout the study. The research team and especially the field workers underwent intensive training to cover this. Role-play also included approaches to community entry, counseling, confidentiality, etc.

### ***Research Stage***

The core group who managed the ECI KZN team met on a regular basis to ensure that the process agreed upon by the key stakeholders was implemented successfully. ECI KZN Committee Meetings<sup>7</sup> were held at least every 3 months. All meetings were minuted and records kept. Progress reports on the study were conveyed to all the stakeholders through regular meetings and email updates.

As the 6 ECI KZN research sites were scattered over vast distances with poor communication networks, a computer terminal with permanent internet access and e-mail was provided at each site. Site representatives were trained in computer literacy and basic biostatistics. This technical intervention significantly improved communication with the sites, enabling them to broaden their links and collaborations, build up the confidence and skills and knowledge base of participants, provide a cohesive network among participants, and facilitate solidarity and enthusiasm for the project. It also served as a powerful platform for the information collection, analysis, and dissemination components of the project.

A unique aspect of this initiative was the close working relationship the group had, which developed trust and coherence through various joint initiatives and ventures such as team building exercises and social functions. This served as an important forum in which to build skills as well as bridge relationships separated by distance.

### ***Post-Research Stage***

As results came out from the research team, the results were documented and acted upon immediately. This ultimately meant that a lot of the work remains unpublished as the research team moved to implementation.

The final results were disseminated soon after the study was completed. They were first communicated by means of half-day workshops held at each of the sites at the end of the research component of the project.

The dissemination of the results was timely from an implementation point of view and from the view of the stakeholders and team members, although it significantly delayed publication of the work and findings. Unfortunately, resources for communication were insufficient as a result of which staff that should have been involved in publications became involved in the communication process.

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<sup>7</sup> Members of Executive Committee listed in Appendix II Additional Information

Public health implications of the research were discussed at a committee meeting level, but probably not adequately.

The backing of reputable international collaborators, such as the HAI, as well as the approval of WHO, UNAIDS, FHI was important to the subsequent utilisation of the research findings.

The involvement of all the stakeholders, who collectively developed the research question, ensured that the research process allowed optimal utilization of the results, and most importantly the implementation of the recommendations.

### **Communication**

All the sites identified that the most important enabling mechanism in the relationship was the communication strategy and regular meeting and updates of the research, which was facilitated by the computer link-up provided. The collaborative environment allowed stakeholders to share knowledge and obtain access to information and training which could improve patient care, as well as to funding to scale up their activities.

Fact sheets summarising the research results were made available to the media to ensure information achieved maximum coverage in the community. Given the implications of the funding involved, there was significant local and international media interest, with a substantial number of articles being printed. At least 50 were known to the authors.

The stakeholders were also involved in communicating the results of the study to their respective communities.

### **Macro contextual factors**

There were also some barriers to research uptake. For instance, there was a lack of clear policy on internationally accepted best standards of care, such as antiretrovirals for the prevention of mother to child transmission, the prevention of transmission through sexual assault, and HAART. Also, there was limited availability of funding which flowed freely to the communities involved. In addition there was the prevailing political situation with respect to South Africa's national strategic plan for HIV/AIDS created certain uncertainties with respect to the availability of antiretrovirals and the cost implications of providing them. A tenuous relationship between some stakeholders in HIV/AIDS treatment, prevention and care programmes slowed the process, often causing disagreement relating to research priorities, and mandate to provide antiretrovirals, amongst others. This process required very skilled management from the project team to maintain cohesiveness.

### **Scale-Up and Utilisation**

According to the Clinical Manager at South Coast Hospice, the research team addressed the practical aspects for scale up and utilisation of the results and sought input from those affected or practically involved in HIV and AIDS programmes. Having the NGO's as partners in the study was important at the application stage as they are functional at a community level and also have a full understanding of the community dynamics.

The first outcome was the implementation of a comprehensive course in HIV/AIDS, aimed at managers (3 one-day workshops presented at six sites – accessed by utilising the Red Cross Flying Doctors Aeroplane), and doctors and nurses (a nine day clinical workshop held centrally).

Due to the urgency of the team to respond to the priorities identified in the research, evaluation of subsequent strategies was poorly done. Overall the outcomes of the research and the implementation of the training, involving all the stakeholders were positively perceived. Training that was implemented was

internally evaluated by questionnaires, and received a positive response, highlighted by the consistent attendance of all delegates.

Involvement of all the stakeholders in the proposal writing, as well as all stakeholders receiving funding for implementation of the fund approved by the Global Fund to fight AIDS, Tuberculosis and Malaria was positively seen. Results and key priorities of the research were imbedded in the multi-disciplinary proposal “Enhancing the Care of HIV/AIDS infected and affected patients in resource-constrained settings in KwaZulu-Natal”, which was successfully funded in 2002 for USD 72 million. The main objectives of the proposal were: Cementing collaborative activities between key stakeholders in HIV/AIDS prevention, treatment and support programmes, for example expanding best practices learned at the ECI KZN sites, and extending home-based care models to monitor patients on HAART for compliance and side effects.

### ***Evidence Base***

The ECI KZN team were committed to ensuring that the research results were presented at national and international conferences, such as the Barcelona 2002 AIDS conference, the Durban, South Africa, AIDS Conference 2003, the Chiang Mai Home Based Care Conference 2001, and the Ouagadougou HIV/AIDS STI conference in 2001. Team members were allowed the opportunity to present their work. Monthly research forums were attended, and presentations made as often as invitations were received.

Latest news and summaries of the e-Groups such as Procaare, HDNet, Af-AIDS, Health Systems Trust Bulletin, Kaiser Network were updated with the fact sheets and research reports. All this information was also made available on the ECI web site, which was mirrored by the HAI in Boston.

### ***Policy***

As a result of the study findings, there were initially demands from the public for changes to policy/services, but as part of a larger social movement in South Africa, mainly driven by the Treatment Action Campaign. It is difficult to gauge a direct relationship between policy changes (planned or implemented) and the study findings. The GFATM proposal was meant to build a foundation of widespread provision of ARV. The South African government made this official first, then 2 years later allowed the GFATM money to flow to KZN.

### ***Advocacy***

South Coast Hospice confirmed that as a result of the study the NGO community advocates on provision of prevention, curative and palliative care services, using a comprehensive approach to care.

### ***Programmes***

Research findings were used in the planning of interventions in each of the research site’s districts, as well as on a province-wide level. The priority needs ranking / analysis, along with the results of the research was used to inform an immediate response based on the research, which included clinical HIV/AIDS training for health professionals, and fund raising for the scale-up of priority activities identified. Various programmes have approached the research team for assistance with scale up of/changes to their programmes as a result of the findings, depending on each programme’s strength. For academia it has mainly been the postgraduate level clinical training, and other operational research related to the findings.

There have been changes to availability of services/products/behaviour of the community as a result but predominantly as a consequence of government policy and programmes. Funds from the GFATM have significantly both directly and indirectly, improved the government’s prevention, treatment, care and

support programmes (implemented with GFATM funds by academia, the NGOs, private sector AND government).

The Clinical Manager at South Coast Hospice states that programmes have increasingly encouraged destigmatisation of HIV and AIDS, making it a chronic managed disease. In general, the positive outcomes of the study from the NGO perspective have been scaling up of services for HIV and AIDS affected and infected communities, and provision of mentorship to emerging community-based organisations.

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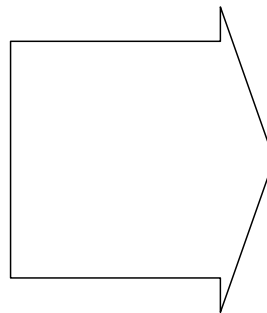
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## Impact of Maternal Syphilis on Pregnancy Outcome in Tanzania

Factors	Pre-research	Research	Post-research	Scale-up Activities
<b>Research Process</b>	<ul style="list-style-type: none"> <li>• Previous research on maternal syphilis in Tanzania looked at other outcomes. This study addressed a knowledge gap.</li> <li>• Team consisted of researchers from LSHTM, ITM and NIMR, all of whom had worked together before.</li> <li>• Funded by Wellcome Trust</li> </ul>	<ul style="list-style-type: none"> <li>• Study designed by all three partners</li> <li>• Local researchers worked together with experienced personnel from LSHTM and ITM</li> <li>• Team worked closely with local health authorities in Mwanza and AMREF.</li> <li>• Staff at the government hospitals carried out the fieldwork.</li> </ul>	<ul style="list-style-type: none"> <li>• Follow up assessment carried out to see how the policy is actually implemented</li> <li>• Assessment brought to light reasons for low levels of syphilis screening in Tanzania</li> </ul>	
<b>Stakeholder involvement</b>	<p><b>Stakeholders:</b> LSHTM, ITM, NIMR Tanzania.</p> <p><b>PRE-RESEARCH:</b> Research question developed by LSHTM in collaboration with National Institute of Medical Research, Tanzania and ITM.</p> <p><b>RESEARCH:</b> All partners were represented on the research team</p>			
<b>Communication</b>	<ul style="list-style-type: none"> <li>• Stakeholders kept informed of progress through reports and meetings.</li> <li>• Seminar held at which findings disseminated to local bodies involved in the study as well as those interested in STI issues</li> <li>• Meeting held in Dar es Salaam for MoH and donors to promote rapid tests as a possible solution for low levels of testing</li> </ul>			
<b>Macro Contextual factors</b>	<p>ARV funding and general high levels of funding in the area of HIV makes it unattractive for health workers to be involved in this kind of research (as there are less funding opportunities); however, funding for programmes for the prevention of mother-to-child transmission of HIV offer an unprecedented opportunity to improve the coverage of syphilis screening programmes for pregnant women.</p>			



Application/Utilisation
<b>Evidence Base</b>
<ul style="list-style-type: none"> <li>• Findings filled knowledge gap regarding impact of syphilis on pregnancy outcomes, and the efficacy and cost-effectiveness of single-dose penicillin treatment.</li> <li>• Findings presented at conferences and published in peer-reviewed journals.</li> <li>• UNDP and NIMR to help the research team in piloting rapid test kits in antenatal clinics in Mwanza.</li> </ul>
<b>Policy</b>
<ul style="list-style-type: none"> <li>• Development of “National Guidelines for Screening and Treatment of Syphilis during Pregnancy” in April 2004 as confirmed by J Chagalucha.</li> </ul>

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## **Impact of Maternal Syphilis on Pregnancy Outcome in Tanzania**

### **Description of Research**

Maternal syphilis is a common problem that has been associated with perinatal mortality and morbidity in many parts of sub-Saharan Africa. In Africa, 500,000 babies die of syphilis every year - more than as a result of contracting HIV. This study was conducted by researchers from the London School of Hygiene and Tropical Medicine, the Institute of Tropical Medicine (Antwerp), and the National Institute of Medical Research, Tanzania. The aim was to see the impact of single doses of long-acting penicillin on women testing positive for syphilis and to study the extent to which maternal syphilis affects pregnancy outcomes. The findings confirmed that syphilis was still a common cause of perinatal death and that a single dose of penicillin is effective.

### **Research Process**

#### ***Pre-Research Stage***

Tanzania was selected for this study because the team had already been working there on STIs and knew that syphilis was an issue there. While a policy was already in place whereby single doses of long-acting penicillin were given to women testing positive for syphilis, it was not known how effective that was. Another gap in knowledge was the extent to which maternal syphilis affects pregnancy outcome. This study was seeking to confirm impact and to see if recommended treatment was effective. The study was carried out between 1997-2001 and the results were published in 2002.

The study was developed by a team within the Department for Infectious and Tropical Diseases, London School of Hygiene and Tropical Medicine (LSHTM), in collaboration with the Institute of Tropical Medicine (ITM), Antwerp, and the National Institute for Medical Research (NIMR), Tanzania. LSHTM has previously been collaborating with both institutes on several projects for many years. This study fitted in with others that were going on with the partners at that time. The current director of NIMR previously obtained his Masters degree through LSHTM and so was already familiar with the LSHTM team and worked closely with them on the proposal. The design was submitted to the local ethics committee for approval. The actual proposal was submitted for funding by LSHTM to the Wellcome Trust as part of a clinical research fellowship.

Stakeholders in this study were the LSHTM, ITM and NIMR. Beneficiaries were women in Tanzania and other parts of Africa, as well as other developing countries where maternal syphilis is common. Dr. Changalucha of NIMR states that the level of involvement of the MoH in studies depends on, among other things, the availability of funds for non-research activities. As this project had relatively limited funds, the MoH at the national level had limited involvement at this stage, though the health departments in the region and district were heavily involved.

#### ***Research Stage***

In carrying out the actual research, the LSHTM and ITM team worked closely with their local counterparts at NIMR as well as others in Mwanza, to include the Regional Medical Officer (RMO), the Municipal Officer of Health in Mwanza town under whose jurisdiction the antenatal clinics were, and AMREF. NIMR's role was data management and laboratory analysis. Its statistician and several data entry clerks managed the data collected from the field, while Dr. J Changalucha and a team of four technicians were responsible for the laboratory work. The fieldwork, which was hospital-based, was carried out by staff working at various government hospitals: Sekou Toure Hospital (Government regional hospital); Makongoro Antenatal Clinic (under the Regional Medical Officer); Bugando Medical Centre (referral hospital); Sengerema District Hospital.

Dr. Chagalucha confirms that while no formal training was provided to the local researchers, the NIMR laboratory team was trained on a method of bacterial vaginosis through the LSHTM initiative. The NIMR statistician worked under an experienced statistician from LSHTM. However, several NIMR staff have had previous formal training through its collaboration with LSHTM in other projects.

All the partners and local health authorities involved in the study were kept informed of the progress of the study at regular intervals, through meetings and annual reports.

### ***Post-Research Stage***

The outcome of the study was very satisfactory with results showing that syphilis was still a common cause of perinatal death and that a single dose of penicillin is effective. The treatment was also found to be very cost effective, in fact one of the most cost-effective health interventions (\$10 per disability adjusted life year saved (DALY)).

A seminar was held to present the final findings to all those involved, which included the clinics, laboratories, medical officers, AMREF, as well as representatives of the MoH and others in the region interested in STI control.

The NIMR has its own dissemination activities and ensures that findings from studies that it conducts are disseminated to the participating communities and nationally. It presented findings from this study at annual meetings that it organised. NIMR is, in general, trying to improve its dissemination strategy for research findings to stakeholders especially policymakers whom they think are crucial if the findings are to be translated into policy and practice.

### **Communication**

Findings have since been disseminated to a wider audience through articles published in journals (see Publications list) and conference presentations:

- 14th meeting of the International Society of Sexually Transmitted Diseases Research. Berlin, Germany, 2001
- International Conference on AIDS/STD in Africa. Ouagadougou, Burkina Faso, 2001
- XV International AIDS Conference, Bangkok, Thailand, July 2004
- 16th Biennial meeting of the International Society for Sexually Transmitted Diseases Research, Amsterdam, the Netherlands, July 2005

### **Application/Utilisation**

Having shown that the intervention is effective in principle, the team were then interested to see how it worked in practice, that is, since there was already a policy in place promoting screening for syphilis, it remained to be seen how the policy was implemented. An LSHTM team member then carried out a stakeholder analysis in different regions of Tanzania to assess coverage of the programme and to seek the views of health service personnel, pregnant women and Ministry of Health officials.

Disappointingly, only about 30% of women were found to have been screened and treated for syphilis, despite the fact that there was an effective intervention. Reasons for this varied: screening for syphilis is often seen as the responsibility of either the STD programme, STD/AIDS control programme, or MCH programme with the result being that none accepts overall responsibility for it. Many people on the ground are also not familiar with syphilis or its implications for health. Another important factor is the heavy workloads of nursing staff in antenatal clinics, who may not prioritise the testing of samples; they may also not be trained or motivated to do the test. These issues are now being addressed by the research team. One possible solution in the case of testing was having one that is simpler and quicker. New, rapid point of care tests for syphilis, which do not require equipment or electricity, were evaluated by the

research team in Mwanza, in collaboration with the WHO. The tests were found to be sensitive, specific and user-friendly.

Dr. E. Ndyetabura of the UNDP HIV/AIDS/STI Programme in Tanzania first learnt of these tests through personal contacts with some of the research team in Mwanza (NIMR and AMREF). He was later invited to a meeting by the WHO STD Working Group in Geneva where the subject was raised and he volunteered to arrange a dissemination and research knowledge-sharing meeting in Dar es Salaam. This meeting was held in February 2005, and was attended by officials from the Ministry of Health and a number of donors who expressed interest in trying to get the tests approved and procured. The recommendation from the meeting was to pilot the rapid tests in a wider geographical area, under real field conditions. Since then they have been made available on WHO's procurement programme which makes them cheaper because they are bought in bulk. The long-term aim is to find companies willing to produce them locally.

### ***Policy***

The NIMR assisted the Reproductive and Child Health Section of the MoH in the development of the National Guidelines for Screening and Testing of Syphilis during Pregnancy as confirmed by J Chagalucha. The final guideline document was produced in April 2004.

### **Macro-contextual factors**

With much of the attention being directed towards HIV and AIDS, programmes in Africa screen women for HIV but not for syphilis. Knowledge and interest in syphilis is also comparatively low. Since the study the research team has trained doctors in Tanzania on STD diagnostics. The NIMR has also been encouraging the MoH to build on the HIV testing programme to include syphilis testing and interest in this has been expressed by the MoH.

The research team now aims to pilot the rapid tests in antenatal clinics in Mwanza with the help of NIMR, focusing on clinics where current tests are logistically difficult to implement. UNDP wishes to assist the MoH and partners in scaling up testing of the rapid test kits and by actively getting involved, it hopes the MoH will be in a better position to hasten the review of the current guidelines and adoption of new technologies.

Tackling syphilis is an uphill struggle as attention has been diverted to HIV/AIDS as a result of which syphilis has been forgotten. It would actually be beneficial to the battle against HIV/AIDS to screen for HIV and syphilis at the same time, as it would be more cost effective. While not much progress has been made so far, this issue was discussed at the scale up meeting where it was felt that since there are promising rapid tests, which could use blood for testing for syphilis as is done for HIV, this makes integration a very real possibility. The priority was to make sure pregnant women had the opportunity to be screened and move on to integration with other programmes. With funding being a major limitation, Dr. Chagalucha says that the NIMR is now in collaboration with MoH and other partners such as WHO and UNDP to see how these technological developments can be used to scale up syphilis screening in Tanzania.

### **PUBLICATIONS**

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### Social Marketing of Pre-packaged treatment for men with urethral discharge (Clear Seven) in Uganda

Factors	Pre-research	Research	Post-research	Scale-up Activities	Application/Utilisation
<b>Research Process</b>	<ul style="list-style-type: none"> <li>Study initiated by USAID Uganda and STD/AIDS Control Programme, MoH Uganda</li> <li>Funded by USAID Uganda</li> <li>Intervention designed by MRC in consultation with partners</li> <li>Ethical standards approved by Ugandan Virus Research Institute</li> <li>Training of dispensers was conducted by AMREF.</li> </ul>	<ul style="list-style-type: none"> <li>MRC carried out fieldwork and data analysis.</li> <li>CMS implemented the social marketing component</li> <li>Except for three non-Ugandan researchers, team members were all local staff</li> <li>Due to delays in introduction of the kit, both control and intervention parts of the study had to be done simultaneously</li> </ul>	<ul style="list-style-type: none"> <li>A high quality report produced based on rigid research by a reputed research agency</li> <li>Findings agreed with stakeholders</li> <li>Results highly relevant for Ugandan context</li> </ul>	<ul style="list-style-type: none"> <li>MoH work plans included budgetary allocations for scale up of kit provision to other districts.</li> </ul>	<b>Evidence Base</b> <ul style="list-style-type: none"> <li>Peer-reviewed publication and conference papers</li> <li>Similar study (Stop-Z pilot) currently underway in Cambodia.</li> </ul>
<b>Stakeholder involvement</b>	<b>Stakeholders:</b> USAID, MoH, health providers, private clinic and drug store staff, medical and public health policy makers, potential clients and their partners. <b>PRE-RESEARCH:</b> Finalised the study methodology <b>RESEARCH:</b> Members of Technical Advisory Committee formed to oversee the study. Key informants in the study.				<b>Policy</b> <ul style="list-style-type: none"> <li>Policy changed to permit distribution of kits by private sector</li> <li>MoH budgets allow for kit provision to other districts.</li> </ul>
<b>Communication</b>	<b>RESEARCH:</b> Regular reports to stakeholders and interim reports produced for USAID. The head of the AIDS Control programme and the Commissioner for Communicable Diseases were also regularly debriefed on the progress of the study. <b>POST-RESEARCH:</b> <ul style="list-style-type: none"> <li>Dissemination workshop held to which whole spectrum of STD/HIV/AIDS interest groups such as District Medical Officers and NGOs were invited.</li> <li>Communication roles to share final findings divided among the research team.</li> </ul>				<b>Programmes</b> <ul style="list-style-type: none"> <li>Pre-packaged treatment kits are still being sold in Uganda</li> <li>PSI providing STI treatment kits in India, Benin, Togo, Madagascar, Uganda, Pakistan, Myanmar, Cambodia, Nepal.</li> </ul>
<b>Macro contextual factors</b>	Existing Ugandan policy did not permit distribution of antibiotics by drug stores, hence initial opposition to the study by the National Medical Association and the National Drug Authority.				

## Social Marketing of Pre-packaged treatment for men with urethral discharge (*Clear Seven*) in Uganda

### Description of Research

A social marketing programme of pre-packaged treatment for men with urethral discharge (*Clear Seven*) was implemented in Uganda. The initiative was evaluated to see how feasible, acceptable, and effective it is as a means to treat STDs, and also thereby preventing HIV. It was found that pre-packaging of treatment kits for male urethral discharge is feasible, acceptable and effective in Uganda. Policy makers, regulatory agencies and health care providers accepted and approved of the product concept, including the sale of *Clear Seven* in the informal and commercial sector through social marketing. It was recommended that the distribution of *Clear Seven* be expanded to other parts of Africa.

### Research Process

#### *Pre-Research Stage*

The aim of the study was to see whether availability and accessibility of quality services for STDs could be improved through social marketing. Of importance was addressing the need to change policy to permit outlets such as drug shops to distribute the treatment kit, which they were not allowed, though in reality it did happen. Hence, in that sense it may be stated that an indirect policy objective was to relax the strict, almost impossible to reinforce, policy of having antibiotics dispersed only by pharmacies – all located in the big cities- and public health sector facilities – at that time severely underused by the population. Data suggests that drug shops are consulted by the poorest strata of the population, which makes it relevant to focus on the informal sector<sup>8</sup>.

The study was initiated in 1995 by the USAID office in Kampala, Uganda in collaboration with the STD/AIDS Control Programme, Ministry of Health, Uganda. USAID was at this point looking at various interventions to address the HIV epidemic and so decided to socially market a pre-packaged treatment for men with urethral discharge (MUD) in Uganda as one of the ways to address the ineffective treatment of STDs. The Government of Uganda was also keen, mainly because other methods to improve access to high quality STD care need a lot of resources and time and, therefore, it considered the study to be both of high priority and relevance.

This was not an original idea; it had been tried before in Cameroon in 1993 (called MSTOP) and failed due to several reasons: (1) the concept was too innovative. (2) Being very much into integrated primary health care services for all, the MoH was strongly opposed to vertical approaches; 3) the whole concept of syndromic management of STIs was still very new and viewed with suspicion by senior dermatovenerologists with strong influence in the MoH; and 4) the idea of having a product available to men without prescription, i.e. bypassing the medical practitioner and encouraging self-medication, was regarded as anathema by the same senior specialists.

According to J Cutler, for the same reasons that it failed in Cameroon, it was believed that it was a useful product that would work in Uganda. The time when the whole idea was being conceptualised and consolidated by the research team, the African Regional AIDS conference was held in Kampala (1993), and that enabled the research team to discuss at length with both F Crabbé (technical advisor to PSI pilot in Cameroon) and Tim Manchester (PSI Head in Cameroon) what went wrong with MSTOP in Cameroon. In designing the project, an effort was made to learn lessons from Cameroon and then look at the needs of Uganda and tailor the product that the team developed to fit the local needs better and also overcome some of the obstacles faced in Cameroon.

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<sup>8</sup> See Jacobs B, Kambugu F, Whitworth J, Pool R. STD management in Uganda's private-for-profit formal and informal sector and patient compliance with treatment. *Sexually Transmitted Diseases* 2004, **31**: 650-654



Unlike the Cameroon study, the Uganda team had the benefit of more time and learning from the mistakes of the Cameroon study. In Uganda, more time was spent in developing the product, the team were more patient and persuasive, more questions were asked and information was brought to the table. In fact, in the case of certifying what was known about treatment seeking behaviour, it was possible to identify researchers to do small studies to support the need for this. This patient approach helped overcome objections and hostilities towards the concept.

J Cutler says that the team often had to prove themselves to the local stakeholders. For instance, if men suffered from urethral discharge syndrome, the legitimate health practitioners were often the last source of treatment approached, which was a widely recognised fact in Uganda, though not officially accepted and so had to be demonstrated by the team. Many public facilities experienced difficulties with the drug supply from the central medical stores, impairing their perceived quality of care and adversely affecting health seeking at these facilities. The kit could have greatly contributed to improving STD management at public facilities. STDs were one of the main reasons for outpatient consultations at many public health facilities.

The ethical guidelines for the study specified that only qualified personnel, even in the informal private sector, would handle the kits, and that the research would be objective. Perhaps the only ethical dilemma was regarding the use of mystery clients to visit the drug shops. While this is a method used frequently in social science research, it was debated whether it would be fair to use subterfuge in this study. An agreement was finally reached when it was realised that the purpose would not be served if the identity of the mystery clients was revealed to the drug shop staff and that the wider purpose of the study may not be achieved.

The research partners in the study were: Medical Research Council Programme on AIDS, Uganda Virus Research Institute, Entebbe; STD/AIDS Control Programme, MoH; Mulago Hospital, Kampala; Commercial Market Strategies (CMS) Project, Kampala; The Futures Group International, Kampala; National Drug Authority (NDA) and Clinical Epidemiology Unit, Makerere University Medical School, Kampala; USAID Uganda.

### ***Research Stage***

A Technical Advisory Committee was set up to provide broad oversight and advocacy for the project. Headed by Dr. F Kambugu of the STD/AIDS Control Programme, MOH, it included representatives from USAID Uganda, CMS, the National Drug Authority and Clinical Epidemiology Unit, the Medical Research Council Programme on AIDS, and donor funded HIV/AIDS organisations.

In Uganda, there are severe restrictions on who can legally dispose, prescribe and dispense drugs and initially the NDA and Clinical Epidemiology Unit at Makerere University opposed the study design. An important factor that ensured participation of the National Drug Authority and Clinical Epidemiology Unit at Makerere University was their actual involvement in the study, which helped avoid potential conflict. Even though the test kits went against Ugandan policy, given the gravity of the HIV epidemic in Uganda at the time and the recognition that various methods need to be adopted to address the problem, all the stakeholders were subsequently willing to overlook the policy issue in order to achieve a greater gain.

Involvement of the STD/AIDS Control Programme, while it had a bias, in some ways helped. In general the interest in identifying ways to treat STIs and the strong commitment by the Ugandan Government, USAID, CMS Project and the Technical Advisory Committee to use the positive results to improve health in Uganda helped in the uptake and implementation of the findings.

J Cutler says that perhaps a turning point was when the team managed to get one of their Ugandan colleagues to shift from a neutral to highly positive stance. If he had been won over earlier, giving the MoH greater ownership of the process (until now all those driving the initiative were non-Ugandan), it

may have moved more swiftly in terms of getting acceptance and approval. Once he came on board, things moved very fast as he was able to fight the battle more convincingly.

The best study design would have been a randomised controlled trial but there were several issues:

- The delayed introduction of the *Clear Seven* kit: several problems were encountered, such as the team having to prove certain facts to the stakeholders, resulting in the delay. **what problems?**
- The study subjects were primarily informal private practitioners (drug shops) who were conducting illegal practices (selling antibiotics) whereby it took a long time for the interviewers to build rapport and gain their trust. As a result the study became a before-after (or during) trial.

The design had to be altered subsequently because of delays in introduction of the kit. As a result the control and intervention side of the study had to be conducted one after another rather than simultaneously.

In order to encourage the participation of the private clinic and drug store owners, the CMS Project Team, who were responsible for the social marketing of the kits, made site visits to assess the clinics and drug shops individually. Selected clinics/shops were then invited to participate in the one-day training; a travel allowance and lunch was provided. In some cases they stayed overnight (paid for by CMS) in order to be able to have a full day of training. Marketing materials were also produced by CMS that designated the shops/clinics as *Clear Seven* providers, thereby setting them apart from other (competing) drug shops and clinics.

The marketing strategy for *Clear Seven* was highly appropriate according to E Gardiner of the CMS Project, given the circumstances in Uganda, particularly the concerns about distribution of antibiotics in drug shops and the treatment behaviours of men. But the fact that the programme required individual selection and training of drug store staff was a constraint to expansion of product availability. The need for controlled distribution was counterbalanced by a preference for national communications to inform the entire population about the kit – but national level communications were not feasible, as the team did not want to have customers seeking a product that was not available in their district. Under these circumstances, it was always difficult to demonstrate in the rollout phase that the product could reach critical mass to justify its continued marketing.

#### ***Post-Research Stage***

J Cutler says it was a long process (5 years from stage of conceptualising and developing the product) getting the necessary agreements from a variety of stakeholders (the NDA being one of the major ones, also the physician organisations and the pharmacists organisations) to the pilot test marketing of it, which was then evaluated. By the time the findings were released and recommendations made, the team had overcome these obstacles so gaining acceptance of the findings from the stakeholders was a *fait accompli*.

#### **Communication**

Communication roles to share final findings were divided among the research team. For example Amref, who were responsible for training the health staff, shared the findings with those trained while drug shop owners and private clinic staff were informed by the CMS Project.

Dissemination activities included: CMS' *Clear Seven* coordinator presented the findings at a workshop in London with DFID and other stakeholders; USAID and the Ministry of Health presented the study at the AIDS Conference in Durban; the study and programme was presented to PSI in Washington and at PSI's regional Eastern and Southern Africa meeting. PSI's 'The Use and Effectiveness of Treatment Kits' (2001) documents lessons learned from social marketing of MSTOP in Cameroon and *Clear Seven* in Uganda and provides guidelines for the implementation of future projects. Overall the report shows that a supportive environment from national government bodies is essential to the success of introducing the pre-package treatment. (see [www.psi.org](http://www.psi.org)).

## **Macro contextual factors**

There was considerable delay in starting the pilot, mainly because of opposition by the medical establishment (National Medical Association and NDA). This was partly circumvented by putting representatives from these bodies on the study's steering committee. But social marketing of antibiotics by lay people can be considered a threat to the medical profession. It can also be seen as legitimising illegal practices such as selling antibiotics—that are widespread.

Ten years later, things have changed significantly. Syndromic management of STIs is widely accepted (but not yet in Cameroon, incidentally); many men with STIs are known to self-medicate, even when good quality services are available; and the concept of targeted interventions for high-risk populations is also accepted. A similar study for provision of pre-packaged treatment for MUD is currently being piloted in Cambodia and in this context it has been a lot easier for PSI to obtain the support of the MoH in Cambodia to start their pilot project of pre-packaged therapy for men.

The *Clear Seven* study is a good example of a practical solution to a situation that you often find in developing countries, which is they have very high levels of rules and regulations, standards of integrity on paper, but the situation on the ground is completely different. But in reality there is no proper enforcement of the policies, nor enforcement to deal with the flouting of clear rules and regulations. There is no effort to provide a legitimate solution to an urgent problem. Products and studies like this help break the problem down to show how the system could be made more flexible.

## **Scale-Up/Application**

Scale up happened much later. According to J Cutler, it was always accepted by the research team that this would be a limited pilot because that was all the research team could get the stakeholders to accept. The aim was to use the pilot to address and overcome any concerns or issues that the stakeholders may have, however minor, with the ultimate hope that the activities could be scaled up at a later date once the results were known.

## **Evidence base**

The peer reviewed paper<sup>1</sup> based on the study findings makes the recommendation that the experiment –i.e pre-packaging treatment and distributing it through the private retail outlets- should be extended to other diseases as well as for other STD syndromes. Co-authors of this paper include Dr Kambugu and Dr John Lule of the National Drug Authority. Recommendations include scaling up the distribution to national level and considering other STD syndromes and diseases.

## **Policy**

The MoH welcomed the results and the main policy change was to improve STD management in the private sector through provision of pre-packaged treatment. F Kambugu confirms that subsequent work plans contained budgetary allocations to allow for rolling out Clear Seven to other districts. Implementation of recommendations happened fairly quickly after the release of the findings with the government permitting the sale of the treatment packs. *Clear Seven* is still being sold in Uganda.

E Gardiner states that the MoH was crucial in allowing CMS to include female partners of men with urethritis in the target audience. They also helped to introduce CMS and Clear Seven to the district health authorities.

This study was different from others in that the research question was set by the policymakers who then approached the researchers rather than vice versa, as is often the case. This was the prime reason for its uptake at the policy level.

## **Programmes**

Other countries have since started marketing PPT kits (India, Benin, Togo, Madagascar, Uganda, Pakistan, Myanmar, Cambodia, Nepal).

While no assessment has been done since, anecdotal evidence shows that it is a popular pack with the population in general according to F Kambugu. Follow up research to include non-pregnant and non-breastfeeding partners of MUD is being looked at, though there are issues of how to identify whether a woman is pregnant or not since the kit should be avoided by pregnant women for safety reasons.

Barriers to the study and application of its results include the medical establishment and omission of the public sector from the social marketing initiative: ie the kit was available from private outlets only and not from public health facilities.

*Clear Seven* helped pave the way for a lot of discussion and debate and progress towards the introduction of unit packaged treatments for important diseases such as malaria for children. It had a very beneficial effect in Uganda and paved the way more expeditiously. Malaria treatment is now being made available widely using the same approach

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## Nevirapine for Prevention of Mother-to-Child Transmission of HIV-1 in Uganda

Factors	Pre-research	Research	Post-research	Scale-up Activities	Application/Utilisation
<p><b>Research Process</b></p>	<ul style="list-style-type: none"> <li>The 076 AZT regimen deemed impractical in developing countries because of cost and logistical complexity.</li> <li>Research on simpler, less costly drug regimens for PMTCT identified as high priority by the WHO, CDC, NIAID.</li> <li>Research question formulated to meet an urgent need for PMTCT in developing countries.</li> <li>Nevirapine identified as a potentially efficacious practical intervention because of its unique pharmacokinetic qualities.</li> </ul>	<ul style="list-style-type: none"> <li>Study designed based on what was practical in target setting.</li> <li>Placebo control used because available interventions not practical in developing countries.</li> <li>Later, placebo control dropped after efficacy of CDC/Thai short-course AZT regimen shown.</li> </ul>	<ul style="list-style-type: none"> <li>Fast-track publication in <i>The Lancet</i> bolstered credibility.</li> <li>UNAIDS meeting agenda revised to discuss results and implementation.</li> </ul>	<div style="border: 1px solid black; padding: 5px;"> <ul style="list-style-type: none"> <li>Elizabeth Glaser Pediatric AIDS Foundation administered the "Call to Action" project to support implementation</li> <li>Researchers provided technical assistance in scale-up activities.</li> <li>Nevirapine provided free-of-charge in developing countries.</li> </ul> </div>	<p style="text-align: center;"><b>Evidence Base</b></p> <ul style="list-style-type: none"> <li>Published in <i>The Lancet</i>.</li> <li>South African study confirmed safety and efficacy of nevirapine in 2003.</li> </ul> <p style="text-align: center;"><b>Policy</b></p> <ul style="list-style-type: none"> <li>Uganda MOH recommended nevirapine for PMTCT.</li> <li>UNFPA/UNICEF/WHO/UNAIDS Task Team endorsed nevirapine.</li> </ul> <p style="text-align: center;"><b>Programmes</b></p> <ul style="list-style-type: none"> <li>More than 50 nevirapine programs established in some 17 countries.</li> <li>Nevirapine is standard of care for PMTCT in many developing countries.</li> </ul> <p style="text-align: center;"><b>Practice</b></p> <ul style="list-style-type: none"> <li>Nevirapine programs implemented within a year of the results being released.</li> </ul>
<p><b>Stakeholder Involvement</b></p>	<p><b>PRE-RESEARCH:</b> Local researchers and public health experts involved in research prioritization and study design. Mulago hospital staff consulted on study design.</p> <p><b>POST-RESEARCH:</b> Researchers informed MOH of results, gained its endorsement.</p>				

<b>Communication</b>	<ul style="list-style-type: none"> <li>• Regular communication between researchers and MOH, and between researchers and hospital health staff.</li> <li>• Results announced by Minister of Health, then by press release.</li> <li>• Researchers made presentations in Uganda and internationally.</li> <li>• Extensive media coverage of results.</li> </ul>
<b>Macro Contextual Factors</b>	<ul style="list-style-type: none"> <li>• Timeliness of research results being released just prior to UNAIDS Conference on Global Strategies for Prevention of HIV Transmission from Mothers to Infants.</li> <li>• Policy environment in Uganda conducive to research utilization.</li> </ul>

## **Nevirapine for the Prevention of Mother-to-Child Transmission of HIV-1 in Uganda**

### **Description of research**

HIVNET 012\* was a randomized trial conducted in Kampala, Uganda from 1997 to 1999 to compare the safety and efficacy of a short course of the antiretroviral nevirapine to a short course of the antiretroviral zidovudine (AZT) for prevention of mother-to-child HIV transmission.<sup>1</sup> The trial was supported by the international HIV Network for Prevention Trials (HIVNET), established by the National Institute of Allergy and Infectious Diseases (NIAID) in the United States (US). Family Health International (FHI) coordinated the trial in collaboration with Makerere University in Kampala, Uganda; Johns Hopkins University in Baltimore, MD, USA; the University of Washington and the Fred Hutchinson Cancer Research Center in Seattle, WA, USA; and several other partners.<sup>2</sup>

The study compared two groups of approximately 300 HIV-infected women each. One group of women received a single dose of nevirapine at the onset of labor, and their infants received a single dose within 72 hours of birth. The other group received doses of AZT at the onset of labor and every three hours until delivery, and their infants received twice-daily doses of AZT for a week after birth. Results showed that nevirapine was efficacious for PMTCT: it lowered the risk of HIV transmission by nearly 50 percent. Furthermore, it was 47 percent more effective than AZT for preventing mother-to-child transmission of HIV. Fourteen to 16 weeks after delivery, only 13 percent of infants given nevirapine were infected with HIV, compared with 25 percent of infants given AZT. Side effects and adverse events were similar in the two groups, i.e. the safety of nevirapine was similar to that of AZT.<sup>1</sup>

### **Research Process**

#### ***Pre-Research Stage***

In 1994, an antenatal/intrapartum/neonatal regimen of AZT was shown to reduce mother-to-child transmission (MTCT) of HIV by two-thirds in a US population. This regimen of AZT, known as the “076 regimen” because of the AIDS Clinical Trials Group (ACTG) protocol number, quickly became the standard of care for PMTCT in the US, reducing the number MTCT cases from 907 to 297 in just five years.<sup>3</sup> In developing countries, however, where MTCT rates are estimated to be as high as 43 percent,<sup>4</sup> the 076 regimen was impractical because of its cost (approximately US \$800) and logistical complexity. Women have to be tested for HIV early in prenatal care, adhere to a lengthy drug regimen with several doses daily, be intravenously infused with the drug during labor and delivery, and refrain from breastfeeding; and the infant must be given six weeks of treatment – all factors that make it difficult to implement in developing-country settings.

In light of these circumstances, the HIV prevention science community sought to identify a simpler, less costly regimen that would be suitable for developing countries. At the World Health Organization (WHO) Meeting on Mother-to-Infant Transmission of HIV by Use of Antiretrovirals, held in June 1994, an international group of researchers, donors, and representatives from the pharmaceutical industry and drug regulatory agencies convened to discuss the results of the ACTG 076 study and to develop the future global research agenda for PMTCT. The group recommended that “simpler and less costly drug regimens...including interventions restricted to the intrapartum period, should be urgently studied in randomized controlled trials.”<sup>5</sup>

In consultation with the United States Centers for Disease Control and Prevention (CDC) and developing-country stakeholders, NIAID ranked research on simple, low cost drug regimens for PMTCT a priority, as

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\* The study is commonly referred to as HIVNET 012. The full title is “A Phase IIB Trial to Determine the Efficacy of Oral AZT and the Efficacy of Oral Nevirapine for the Prevention of Vertical Transmission of HIV-1 Infection in Pregnant Ugandan Women and Their Neonates.”

did the HIVNET. Developing a study to address this research question became the top priority for HIVNET's Perinatal Science Working Group (PSWG).

The PSWG included leading researchers, donors, and public health experts from the US and Uganda. Equal involvement of local stakeholders in research priority-setting and study design lent credibility to the HIVNET 012 study. In addition, these local experts were well-positioned within their respective communities and institutions to lead the way in implementing interventions for PMTCT.

### ***Research Stage***

Nevirapine was identified as a good candidate for evaluation because of its unique pharmacokinetic qualities, including its potency, bioavailability, and long half-life. Originally, HIVNET 012 was designed as a three-arm study comparing nevirapine, AZT, and placebo control. However, as the study was being developed, a significant controversy arose concerning the ethics of conducting placebo-controlled trials in developing countries when a proven intervention (e.g., the 076 regimen) already existed. However, the WHO, CDC, National Institutes of Health (NIH), United States Department of Health and Human Services (HHS), and leading researchers, ethicists, and public health officials from developing countries supported placebo-controlled trials, contending that the only way to truly evaluate the safety and efficacy of an intervention in a target population was to compare it with the standard of care in that setting. The standard of care for HIV-infected pregnant women at the time did not include any treatment at all, so these local and international public health experts made the case that the placebo was an acceptable and appropriate control in these settings, and in fact, the institutional review boards (IRBs) in both the US and Uganda approved the study as designed with the placebo, allowing it to proceed.

A few months after the HIVNET 012 study was initiated, the results of a CDC-sponsored trial in Thailand demonstrating the efficacy of another short course of AZT were released. As a result, the placebo control arm of the HIVNET 012 study was dropped. Continuing with the placebo control at this point would have been considered unethical because a regimen theoretically applicable in developing countries had been identified. The HIVNET 012 researchers obtained permission from the IRBs to continue enrolling women in the two active agent arms of the trial (nevirapine and AZT) to inform design of another efficacy trial, which would compare the more effective of the two arms with an appropriate control. This approach was entirely consistent with statements released by the Joint United Nation Programme on HIV/AIDS (UNAIDS), CDC, the National Agency for AIDS Research (ANRS) in France, and other leading health agencies in response to the CDC/Thai study results.

As stated above, HIVNET 012 showed nevirapine to be safe and efficacious for the prevention of mother-to-child transmission of HIV. Furthermore, it showed that nevirapine was 47 percent more effective than AZT, findings that surprised even the HIVNET 012 researchers. The researchers had hoped and expected that nevirapine would be as or more effective than AZT but had not expected the magnitude of the protective effect shown. After the interim analysis of HIVNET 012 by the NIAID Division of AIDS Data and Safety Monitoring Board (DSMB), the subsequent planned efficacy trial was deemed unnecessary.

### ***Post-Research Stage***

After the Division of AIDS DSMB approved release of the results in July 1999, the HIVNET 012 researchers met with officials at the Ugandan Ministry of Health (MOH) to inform them of the results and gain their endorsement. Together, they designed a carefully-orchestrated plan for releasing the results. The Minister of Health made the first public announcement in Uganda, followed on the same day by issuance of a press release by the NIH in the US. Both the Ugandan and US investigators participated fully in dissemination of the findings, by making a number of presentations locally and internationally.

The dramatic results of the HIVNET 012 study drew considerable interest internationally, prompting autonomous dissemination of the results and endorsements of the intervention. Media worldwide reported on the results: articles appeared in *Africa News Online*,<sup>6</sup> *The New York Times*,<sup>7</sup> *CNN*,<sup>8</sup> *BBC*,<sup>9</sup> and local



Ugandan newspapers. *The Lancet* fast-tracked the study for publication, lending considerable credibility to the results and making the full results officially available for international meetings and policy and program considerations.

The UNAIDS Second International Conference on Global Strategies for Prevention of HIV Transmission from Mothers to Infants took place the first week of September 1999, right after the results of HIVNET 012 had been released and coinciding with the study's publication in *The Lancet*. The research team had hoped to have completed the study before this conference was held in order to take advantage of the gathering of experts to disseminate the information and discuss next steps. The timing was, in fact, advantageous, as the agenda for the conference was modified to discuss the results of HIVNET 012 and how to implement them. At the conference, the UNAIDS' International Working Group on Mother-to-Child Transmission endorsed nevirapine as the most feasible of the five available ARVs for PMTCT in many settings. Also, a "Call to Action" was announced, soliciting the commitment of organizations, foundations, non-governmental organizations, and governments to providing the means necessary to expand PMTCT programs, including the provision of ARVs for PMTCT.<sup>10</sup>

Based on the recommendations made at the Global Strategies for Prevention of HIV Conference, the Ugandan Minister of Health, who participated in the conference, decided to endorse nevirapine as the first-line drug for PMTCT in Uganda. In the beginning of 2000, the Ugandan government officially recommended nevirapine and the CDC/Thai AZT regimen for PMTCT and launched a national PMTCT program.<sup>11</sup> The justification for the Ugandan MOH's rapid formulation of policy regarding ARVs for PMTCT was articulated by the Minister of Health in the forward of the *Policy for Reduction of the Mother-to-Child HIV Transmission in Uganda*, issued in July 2001. "There is need to translate the research findings into practical intervention activities that are integrated within the normal health care delivery system...For this to be done well, there is need for the development of a policy document that can guide the different sectors, set the standards and ensure quality control of the implemented activities. Hence, the rationale of this document."<sup>12</sup>

In October 2000, the UNFPA/UNICEF/WHO/UNAIDS Inter-Agency Task Team on Mother-to-Child Transmission of HIV concluded that nevirapine, AZT, and AZT plus lamivudine could be recommended for general implementation and of these regimens, nevirapine was the simplest. Furthermore, they recommended that PMTCT be part of the standard health care services offered to HIV-infected women.<sup>13</sup>

### **Scale-up/Implementation**

The Elizabeth Glaser Pediatric AIDS Foundation, which administered "The Call to Action" project, raised more than US \$15 million within a year of the Global Strategies for HIV Prevention Conference to support the implementation of PMTCT programs. The HIVNET 012 study site in Kampala was one of the first sites to receive an Elizabeth Glaser Pediatric AIDS Foundation grant for an implementation program. Because the scientific director of the Elizabeth Glaser Pediatric AIDS Foundation had served as the chair of the HIVNET PSWG and was keenly aware of and interested in the HIVNET 012 study from its outset, the foundation became involved earlier than it might have otherwise. The HIVNET 012 researchers provided technical assistance in the "Call to Action" project. Other donor agencies soon followed suite, supporting such aspects of implementation as training practitioners.

Boehringer Ingelheim, the manufacturer of Viramune (the brand name for nevirapine), agreed to supply the drug free-of-charge to governments, nongovernmental organizations, and health care providers in developing countries. Axios, which fosters partnerships with the private sector to improve developing-country health care systems, worked with Boehringer Ingelheim and donor agencies to coordinate the supply of nevirapine in Uganda. An important criterion for qualifying to receive a free supply of nevirapine and implementation assistance was the existence of a comprehensive PMTCT program and the ability to commit local resources to implementing the nevirapine program, making it sustainable in the long-term.

Widespread implementation remains a challenge, but in many sites, the intervention has been successful overall because of its simplicity, practicality, and low cost. More than 50 nevirapine programs have now been established in at least 17 countries, and the regimen is the standard for preventing mother-to-child transmission of HIV in many parts of the developing world. Additional research has confirmed the safety and effectiveness of nevirapine,<sup>14</sup> which may encourage governments in other countries adopt it as the standard of care for PMTCT. Provision of PMTCT services has been a vehicle for improving other mother and child health services, including assisted delivery and voluntary testing and counseling for HIV.

### **Research Utilization**

Three Ugandan stakeholders were interviewed, and their thoughts on the factors that acted as facilitators or barriers to the translation of the HIVNET 012 research into practice in Uganda are detailed below. Professor Francis Mmro, who is the chairperson for the National PMTCT Task Force in Uganda was one of the investigators for HIVNET 012, is referred to as “the researcher.” Dr. Saul Onyango is the coordinator of the National PMTCT Program for the Ugandan Ministry of Health and is called “the MOH program manager.” Finally, Dr. Fred Nuwaha, coordinator of the Pediatric AIDS Foundation Program in Uganda, is referred to as “the foundation program manager.”

### **Factors Facilitating Utilization**

#### ***Research applicability***

On the topic of implementing research into policy, the MOH program manager said, “The problem is often that researchers are trying to answer academic questions rather than practical problems. In these cases, policy-makers don’t get informed of results, and policies don’t change.” He asserted that the research environment in Uganda is different, though, because “researchers in Uganda try to anticipate the problem before performing research.” According to the researcher, other significant factors that facilitated the HIVNET 012 research being used in policymaking were the results were clear, and the study was performed in-country. It is also likely that because of the high volume of scientific research being conducted in Uganda, the Ugandan government is more attuned to using research evidence in policy-making.

#### ***Communication***

The researcher emphasized that communication between the researchers and health staff at Mulago Hospital, where the study was conducted, was key to developing relevant study protocols. He also noted that because the researchers communicated throughout the research process with the Ugandan MOH, the MOH more readily took ownership of the study results.

#### ***Policy before practice***

The MOH program manager said the most important facilitating factor for the uptake of research in programs is “policy is considered before practice. The Ministry of Health created an environment in which practitioners wanted to come on board.” In the case of nevirapine, this environment was produced by 1) the commitment of the Ugandan Ministry of Health to PMTCT programs and 2) the timely creation of policies and guidelines for nevirapine use for PMTCT.

#### ***Cost effectiveness***

The researcher reported that even before the HIVNET 012 study, the Ugandan MOH was already seeking a more cost-effective drug regimen for PMTCT. Cost was the primary factor inhibiting the MOH from using AZT for PMTCT, although MOH officials were considering implementing the CDC/Thai AZT regimen at the recommendation of the National PMTCT Technical Committee, when the results of

HIVNET 012 were released. Nevirapine was not only effective, but because of the low cost, it was perceived as feasible to scale up use of nevirapine in Uganda and other developing countries.

### ***Dissemination***

For a year or more after the study was published, the HIVNET 012 research team made a concerted effort to present the results in a range of settings locally and internationally, therefore reaching a broad audience. According to the researcher, because the researchers disseminated the findings in person, rather than by a report, audiences were able to ask questions and the researchers could immediately clarify any possible misunderstandings.

### ***Ease of implementation***

According to the MOH program manager, the smaller dosage and shorter duration of the nevirapine regimen compared to AZT were significant because these characteristics necessitated less counseling by practitioners, making the regimen relatively easier to implement. Similarly, the foundation program manager described it as “user friendly” because it is a simpler regimen for practitioners to administer and for the mother to adhere to.

### ***Partnerships***

The MOH program manager and the researcher believed partnerships with local, national, and international organizations were vital to the initial uptake of nevirapine and to the continually increasing number of PMTCT centers across the country over time. The Ugandan National PMTCT Technical Committee sought partnerships from the beginning, because it recognized that the MOH lacked both the money and medical personnel to implement the programs. Those interviewed named the Elizabeth Glaser Pediatric AIDS Foundation, UNICEF, Doctors Without Borders, the Italian corporation, GTZ, CDC, the United States Agency for International Development (USAID) and local NGOS as critical partners because these organizations helped provide the resources necessary to implement nevirapine use.

### **Barriers to research utilization**

The greatest barrier to the use of nevirapine, according to the foundation program manager, was that approximately 60 percent of Ugandan women give birth at home rather than in hospitals, where nevirapine is usually administered. The Pediatric AIDS Foundation Program in Uganda used a three-pronged strategy to overcome this barrier: 1) pregnant women were encouraged to deliver at hospitals, 2) if women delivered at home, they were encouraged to bring their infant to the hospital to receive nevirapine, and 3) nevirapine was packaged and distributed in two single doses, one for the mother to take before delivery and one for the baby to be given after delivery. Evaluating this strategy has proved to be difficult, because it is hard to confirm whether the mother and the infant actually receive the doses provided to the mother for home use

Another barrier, according to the researcher, is the Ugandan policy to use nevirapine as the standard of care for PMTCT was based on a single study. A subsequent study conducted in South Africa confirmed the safety and effectiveness of nevirapine,<sup>14</sup> and additional research is being done to improve the regimen.

### **Lessons learned**

In the case of HIVNET 012, research was put into practice relatively quickly based on the strength of the study findings and their potential for a substantial public health impact. Other factors that facilitated the research-to-practice process included perceived urgency of the underlying public health problem being addressed, political support, strategic partnerships for implementation, nevirapine's low cost, readily available supplies, and relative ease of implementation.

Lessons that can be taken from this case study are the importance of formulating a research question in response to a health need and designing the study based on what will be practical in the target settings. Partnerships among local researchers, international normative bodies, international research organizations, donor agencies, and the local Ministry of Health are crucial throughout the research and implementation process. Finally, the rapid formulation of policy and provision of resources necessary to implement the intervention are key to bridging the gap between research and practice. Duplicating these steps for other research studies, particularly those testing interventions targeted to developing-country settings, will increase the probability of effective translation of research into practice.

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### Community-Based Distribution in Zimbabwe

Factors	Pre-research	Research	Post-research	Scale-up Activities	Application/Utilisation
<b>Research Process</b>	<ul style="list-style-type: none"> <li>Study initiated by Zimbabwe National Family Planning Council (ZNFPC)</li> <li>Technical assistance provided by Population Council</li> <li>Study commissioned by USAID</li> <li>Ethical standards assessed by Population Council's Internal Review Board and Medical Research Council of Zimbabwe (MRCZ)</li> </ul>	<ul style="list-style-type: none"> <li>Operations research conducted with assistance from ZNFPC</li> <li>Study design replicable in similar settings</li> <li>Independent research assistants hired and trained by Population Council to conduct study</li> <li>Ethical standards adhered to throughout the study.</li> </ul>	<ul style="list-style-type: none"> <li>Results discussed with stakeholders at meetings and roundtable discussions</li> <li>Study findings were made available at the right time when ZNFPC was looking for a new direction for its CBD programme and for ways to address the HIV epidemic</li> <li>Recommendations fed into plans for future CBD programmes</li> </ul>	<ul style="list-style-type: none"> <li>Advance Africa selected to assist ZNFPC in developing and implementing revised CBD programme through: revision of manuals, training, M&amp;E</li> <li>ZNFPC revised the training and procedure manual; STI prevention and HIV/AIDS management included</li> <li>CBD agent recruitment and appraisal process and reporting formats changed.</li> </ul>	<p><b>Evidence Base</b></p> <ul style="list-style-type: none"> <li>Depot-Holder model introduced in 8 pilot districts as per study recommendations</li> </ul> <p><b>Advocacy</b></p> <ul style="list-style-type: none"> <li>Advocacy Kit produced by ZNFPC to create supportive environment for agents</li> </ul> <p><b>Policy</b></p> <ul style="list-style-type: none"> <li>Several policy changes made related to role of CBDs.</li> <li>Scope of CBD agents widened beyond family planning to include STIs and HIV/AIDS</li> </ul> <p><b>Programmes</b></p> <ul style="list-style-type: none"> <li>CBD agents linked to VCT centres</li> <li>CBD agents report on their new activities directly to the ZNFPC</li> </ul> <p><b>Practice</b></p> <ul style="list-style-type: none"> <li>Distribution of oral pills has increased as confirmed by Dr Murwira, Technical Director, ZNFPC</li> </ul>
<b>Stakeholder involvement</b>	<p><b>Stakeholders:</b> ZNFPC, MoHCW, USAID</p> <p><b>PRE-RESEARCH:</b> Designed by Population Council in consultation with ZNFPC and Director of the MCH/FP Unit at the MoHCW</p> <p><b>RESEARCH:</b> Director of the MCH/FP Unit at the MoHCW participated in the design and implementation of the study activities</p> <p><b>POST-RESEARCH:</b> Consulted when developing future plans</p>				
<b>Communication</b>	<p><b>RESEARCH:</b> Verbal progress reports given to USAID and ZNFPC</p> <p><b>POST-RESEARCH:</b></p> <ul style="list-style-type: none"> <li>ZNFPC organised workshops for its branches around the country and for CBD agents to discuss ways forward</li> <li>Consultative meetings also held with USAID and MoHCW to discuss findings</li> <li>Final findings disseminated through conference meetings in east and southern Africa; also written up as a report.</li> <li>Radio serial on HIV and AIDS produced by CDC and Media for Development Trust.</li> </ul>				

## Community-Based Distribution in Zimbabwe

### Description of Research

The Zimbabwe National Family Planning Council (ZNFPC) is responsible for guiding the family planning policy development on behalf of the Ministry of Health and Child Welfare (MoHCW). It implemented two nationwide-service delivery programmes: the Community-Based Distribution (CBD) programme and a small number of fixed and mobile family planning clinics. While the CBD programme made useful contributions to the demand for and use of family planning services in Zimbabwe, DHS data showed a steady decline in this contribution. Situation analysis studies in 1991 and 1996 showed that CBD agents spent most of their time re-supplying existing clients rather than trying to get new acceptors. Condom use also continued to be low in the country. This was especially significant given the high HIV/AIDS prevalence in the country. As a result, the ZNFPC decided to revise its CBD programme to make it more responsive to the reproductive health and service delivery situation. To this end, in 2000, they sought the technical assistance of Population Council and USAID to carry out operations research (OR) to help guide the future direction of the CBD programme. Data was collected through a review of documents, in-depth interviews with key staff at ZNFPC headquarters and provincial levels, interviews with 128 CBDs, 37 Group Leaders, 33 Community Leaders, 23 Environmental Health Technicians, 40 Clinic Nurses, 19 District Nursing Officers and 22 Community Health Nurses, and through 61 focus group discussions with different groups of community members. The study findings confirmed that agent productivity was dropping and programme costs increasing. Recommendations were made to rectify these.

### Research Process

#### *Pre-Research Stage*

Population Council's research experience in Family Planning Community Based Distribution programmes in African countries like Kenya and the collaboration ZNFPC had had with Population Council on other research activities were the main reasons for the ZNFPC approaching them to carry out this study according to ZNFPC Technical Director, Dr. Murwira. Former ZNFPC Director, Godfrey Tinarwo, echoes these sentiments, adding that another factor for approaching Population Council was because of their ability to mobilise resources for the exercise and their ability to build ZNFPC capacity to conduct operations research. Dr. Murwira points out that ZNFPC initially approached and briefly worked with the UNFPA Country Support Team (CST) but did not manage to get the assistance (particularly financial) they were looking for.

Discussions on the study concept were held between Population Council, ZNFPC, and the Reproductive and Child Health (RCH) staff of the MoHCW. The proposal was written by Population Council staff and shared with the partners for input before it was submitted to USAID for funding consideration. The research study design was simple enough to be replicated in any similar setting - review of documents, interviews with key staff and community leaders, and focus group discussions with different groups of community members. The Population Council's Internal Review Board reviewed the proposal for its ethical soundness. The proposal was also submitted to the Medical Research Council of Zimbabwe (MRCZ) for approval of the ethical standards and both Dr. Murwira and G Tinarwo confirm that the ZNFPC were satisfied that these were adhered to throughout the study.

The study design used was the most suitable according to Dr. Murwira and G Tinarwo. It was an exploratory/diagnostic study and both qualitative and quantitative research methods were used. It enabled ZNFPC to gather input from policymakers, programme managers, service providers, CBD

agents, community leaders, clients and the general public to better understand the operations of the CBD programme and come up with ideas on how improvements could be made to it.

The stakeholders for this study were the ZNFPC as it was their programme that was being assessed, the MoHCW due to the family planning policy implications, and USAID because its funds were used to carry out the study.

The study was considered to be timely by the ZNFPC as they realised that they needed an evaluation of their programme to help redirect their efforts. In addition to the falling number of new clients, the ZNFPC needed to know how they could contribute their efforts towards addressing the growing HIV epidemic.

### ***Research Stage***

The study team comprised independent research assistants hired and trained by Population Council. ZNFPC provided all the logistical support required on the ground. G Tinarwo stated that financial and logistical support provided by USAID, ZNFPC and MoHCW were sufficient for the study, which would help strengthen the CBD programme in Zimbabwe and the region.

This study had a short data collection period and so there was no room for formal progress updates, but Population Council gave verbal feedback to both USAID and the ZNFPC. Dr. Murwira says that the ZNFPC's Evaluation and Research Unit (ERU) was part of the research group from conception, through study design, training of research assistants, fieldwork, data entry right up to dissemination of the findings and report writing. The ZNFPC ERU actually coordinated the research and produced quarterly narrative reports to update Population Council (Nairobi) on the progress of the project.

The data analysis framework was discussed with the ZNFPC, although Population Council in Nairobi did the actual data processing. Once the preliminary data was available, a data interpretation session was held with ZNFPC, MoHCW and USAID, before the report was written up.

### ***Post-Research Stage***

Population Council assisted the ZNFPC in designing a dissemination strategy for the results, and also funded the activities, including distribution of the research report within Zimbabwe and hosting meetings. The dissemination strategy had been built into the original proposal for budget purposes, and was renewed when the findings became available.

The results were discussed with a range of stakeholders in the reproductive health sector in Zimbabwe, including MoHCW staff, at meetings and roundtable discussions to solicit their support for its new activities. The ERU staff were co-presenters during the dissemination seminars for stakeholders. All received a copy of the research report. The study answered questions that were priorities to both ZNFPC and USAID and so both were willing to listen to and act on the findings. Suggestions had been made during the data collection exercise on improvements that could be made; these were discussed as part of the results presented to ZNFPC, MoHCW and USAID during dissemination.

All stakeholders jointly made the recommendations as confirmed by Dr. Murwira. These fed into future plans for CBD programmes. Consultative meetings were also held with USAID Zimbabwe and Advance Africa to discuss the findings and possible ways forward.



Soon after the study, ZNFPC began disseminating the findings and discussed them with all their branches. A total of 15 workshops were also held around the country to discuss the findings with ZNFPC field staff and CBD agents and plan a way forward. The ZNFPC ERU prepared the presentations for these workshops. Dr Murwira and G Tinarwo admit that the CBD agents were somewhat sceptical in the first instance. Some of the recommendations were for recruitment criteria to be changed in line with the changes in their role. It had been recommended that the old CBDs be retrenched so that energetic ones could be hired on contract basis to increase efficiency and productivity for the programme. This, initially, was seen by most CBDs as a strategy, which the management had come up with to retrench them. This recommendation was ultimately not implemented due to lack of funds to retrench the old CBDs.

USAID valued the results of the OR as it helped guide them in redirecting their support to the CBD programme. Dr. Murwira and G Tinarwo confirm that ZNFPC was satisfied overall with the way the study was conducted and in particular felt that the findings were easy to interpret, mainly because there was participation of all stakeholders in the interpretation of the results during dissemination workshops. The stakeholders also participated in designing the programme that they wanted to be implemented after the assessment. G Tinarwo adds that the results had revealed a high level of agreement on key issues. Both management and staff at ZNFPC viewed the review exercise as long overdue and the recommendations were seen as addressing real and concrete challenges, which would further raise the profile of an already well-accepted and highly valued community based health delivery programme.

### **Communication**

Both the Research and Communications Units of ZNFPC worked closely in disseminating the research results with additional technical assistance provided by Population Council as confirmed by G Tinarwo. The Head of the Service Delivery Unit under whom the CBD programme was managed provided overall coordination.

The ZNFPC did not produce any communication materials itself. It wanted to produce a radio serial drama in the two local languages on HIV and AIDS and this was done by CDC and Media for Development Trust "Mopani Junction". ZNFPC also wanted to conduct a materials development workshop to produce materials for use by clients and CBDs in the project but funds were never availed by the project.

The ZNFPC also arranged for newspaper adverts to be placed in the daily papers and localised newspapers to disseminate information based on the study findings.

### **Scale-Up/Application**

There was no provision in the original study budget for scale up activities because any such activities would have been absorbed in the ZNFPC programme budget. Dr. Murwira states that the CBD programme is a nationwide service delivery programme with funding being provided by the government of Zimbabwe. The ZNFPC found the study results important, useful and practical, and planned to make use of government funds to implement the research results. Plans were also in place to mobilise additional resources. G. Tinarwo adds that while ZNFPC had a plan for scaling up activities, the major challenge was finding resources to rapidly scale up activities at a time when the Zimbabwean government was hard pressed for financial resources and donors were also withdrawing their support. The invoking of the Brooke Amendment drastically reduced the prospect of significant USAID support, which to a large extent had been expected to complement Government of Zimbabwe support.

Advance Africa was selected by USAID, in consultation with the MoHCW and ZNFPC to assist the ZNFPC in its scale up activities. Advance Africa was selected for its training strengths because the new programme would involve new training.

In 2002, Population Council's FRONTIERS project reviewed the CBD programme to assess the level of utilisation of the original study findings. The review found that:

1. Advance Africa was a valuable partner to ZNFPC, providing technical assistance in reviewing the training and procedure manuals, and in providing training in financial management and on improving the monitoring and evaluation components. Eight districts were identified in which to pilot the revised programme. At the time of the utilisation review, 54 agents had been given refresher training under the revised curriculum.
2. The new procedure manual was revised to reflect the additional responsibilities that the ZNFPC has given to the CBD agents over and above their traditional family planning focus. The revisions also include information on STI prevention and HIV/AIDS management as recommended in the study. Also included in the manual is a commodities supply and management component to ensure continuous stocks of commodities for the agents.
3. The ZNFPC Human Resource Department also reviewed the CBD agent recruitment, supervision and appraisal process to reflect the expanded role of the agent.
4. The ZNFPC developed an Advocacy Kit to support the agents in performing their expanded roles. This kit will enable the agents to provide broader health services and information, besides family planning.
5. Changes have been made to the reporting formats so that the CBD agents report on their new activities to the ZNFPC.
6. Young people and men have also been targeted by the CBD agents as recommended by the study. Previously only women with children were targeted.
7. CBD agents have been linked up with VCT centres in order to have a more effective referral system.

According to G Tinarwo, factors that have facilitated the scale up of activities include:

- Staff and community readiness and acceptance to embrace the recommended changes
- Availability of financial and technical assistance from USAID and Advance Africa
- Parent Ministry, Board and Management support
- Strategic fit and perceived responsiveness to new realities on the ground
- Stakeholder and client endorsement and support
- Evidence based and research driven intervention
- The need to assure institutional survival and relevance at a time when attention was increasingly focussed on HIV and AIDS

He adds, however, that some of the recommendations have been difficult to implement, due to:

- Limited funding from Government of Zimbabwe and ZNFPC
- Failure to retrench older CBDs and recruit new CBDs
- Management capacity weakened as key partner poached staff who were driving the programme
- Staff attrition and reduced morale due to poor remuneration in an hyperinflationary environment
- Loss of USAID support due to the Brooke amendment
- Delays in disbursement and accounting for funds from both Advance Africa and ZNFPC

### ***Evidence Base***

A third model, the ‘Depot-Holder model’ has been introduced in eight pilot districts. As per the OR study recommendations this model is to be tested in terms of operating costs and replicability before it becomes a programme-wide strategy.

In 2003, FHI and ZNFPC carried out a baseline study to provide data for an assessment of the expanded CBD program<sup>9</sup>.

Dr. Murwira says the ZNFPC would like to fully integrate family planning services with Voluntary Counselling and Testing (VCT) for HIV services in its facilities. ZNFPC would therefore like to carry out an operations research project on the integration of family planning services with VCT services.

Dr. Murwira points out that this is still a small-scale initiative and there are plans to upscale and expand if the programme is to have a significant impact on the HIV epidemic. Site-specific assessments might be carried out to ascertain the programme’s contribution in reducing the effect of HIV epidemic if funds permit. In 2004, an impact evaluation survey for the programme was conducted by an independent research agency. The evaluation was, however, aborted after the research agency failed to deliver to expectations.

Reflecting on the study, G Tinarwo feels that perhaps the study could also have focused on CBD clients who are between 15-49 years instead of between 15-29 years.

### ***Advocacy***

Advocacy packages (national) and 8 site-specific packages were produced to support advocacy activities.

### ***Policy***

Policy changes made by the ZNFPC were:

- 1) Expansion of CBD role to include HIV/AIDS
- 2) Integration of FP and HIV & AIDS
- 3) Introduction of Depot Holders to re-supply
- 4) CBD to provide supportive counselling in Community Home Based Care (CHBC)
- 5) Revision of Training and Procedure Manuals
- 6) Review of record keeping and logistics management, management and supervision policies
- 7) An employment contract for CBDs was drafted and is yet to be implemented.

G Tinarwo confirms that both the MoHCW and the ZNFPC Board formally approved the expanded roles of the CBDs as well as the establishment of Depot Holder models in densely populated areas so as to reduce the burden on the CBDs.

### ***Programme***

According to Dr. Murwira, service statistics from the programme’s Management Information System (MIS) indicate that the number of oral pills and female and male condoms distributed has steadily increased since implementation of the programme. The number of oral pills distributed in the first 8 project districts were 192,981 for the period September 2001 to August 2003. The figure increased to

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<sup>9</sup> Nyakauru Ronika, and Pierre Ngom. 2004, “Expanded Community Based Distribution Programme- 2003 Baseline Report”. ZNFPC, Advance Africa and USAID.

436,371 for the period September 2002 to August 2003. From January to September 2004, the number of oral pills distributed was 451,526 in the first 8 districts. There is a need to conduct a detailed study to find out if the costs of the programme have been reduced.

#### **PUBLICATIONS**

1. FRONTIERS OR Results Utilisation Review: *Using Operations Research to redirect a reproductive health programme – Community-Based Distribution in Zimbabwe*
2. CBD Roles Modified to Address Zimbabwe's HIV/AIDS Crisis: FRONTIERS OR Summary 29, August 2002

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## Introducing Emergency Contraception in Bangladesh

Factors	Pre-research	Research	Post-research	Scale-up Activities	Application/Utilisation						
<b>Research Process</b>	<ul style="list-style-type: none"> <li>Workshop on Emergency Contraception (EC) convened by Population Council (PC) in 1997 to present KAP study findings</li> <li>Forum on ECP initiated in 1998</li> <li>Research initiated at request of MoHFW, Bangladesh (1998)</li> <li>Research team: FRONTIERS, Pathfinder International, John Snow, Inc. (JSI), Directorate of FP (DFP)</li> <li>Proposal presented at the request of the government; reviewed by the National Technical Advisory Committee (NTC) of Ministry, Directorate General of Family Planning (DGFP)                             <ul style="list-style-type: none"> <li>Ethical approval by National Ethical Committee and Bangladesh Medical Research Council (BMRC)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Operations research conducted to assess acceptability and feasibility of most appropriate and cost-effective service delivery model</li> <li>Study conducted in Government and NGO institutions.                             <ul style="list-style-type: none"> <li>Ethical protocol adhered to throughout                                     <ul style="list-style-type: none"> <li>IEC materials developed</li> </ul> </li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Preliminary findings were presented to MoHFW before completing all analyses of the findings</li> <li>Implementation needs of the research results were identified and addressed by the partner organisations including DGFP and at workshops, review meetings and seminars at the national level.</li> <li>The four partners including DGFP finalised the policy recommendations.                             <ul style="list-style-type: none"> <li>Researchers conducted workshop for press to communicate need for ECP in Bangladesh</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Technical assistance from FRONTIERS Programme</li> <li>UNFPA funded scale up (supplies and training funds)</li> <li>BCC and training materials developed during study approved by Government; this</li> </ul>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #cccccc;">Evidence Base</th> </tr> </thead> <tbody> <tr> <td> <ul style="list-style-type: none"> <li>Presented findings at international and regional seminars</li> <li>Printed publications produced</li> </ul> </td> </tr> <tr> <th style="background-color: #cccccc;">Policy</th> </tr> <tr> <td> <ul style="list-style-type: none"> <li>Government of Bangladesh introduced ECP into FP programme in 2001</li> <li>Policy change in NGOs working in Bangladesh to include ECP</li> <li>In 2004, Government recommendation to expand ECP to rest of country</li> </ul> </td> </tr> <tr> <th style="background-color: #cccccc;">Programmes</th> </tr> <tr> <td> <ul style="list-style-type: none"> <li>297 Master Trainers trained who in turn trained 2,264 trainers at district level</li> <li>EC introduced in all 64 districts of Bangladesh.</li> <li>40,009 service provider trained on ECP</li> <li>2,134 NGO service providers were trained from the country</li> <li>Many service delivery NGOs including NSDP (USAID funded NGOs) included ECP in their service.</li> </ul> </td> </tr> </tbody> </table>	Evidence Base	<ul style="list-style-type: none"> <li>Presented findings at international and regional seminars</li> <li>Printed publications produced</li> </ul>	Policy	<ul style="list-style-type: none"> <li>Government of Bangladesh introduced ECP into FP programme in 2001</li> <li>Policy change in NGOs working in Bangladesh to include ECP</li> <li>In 2004, Government recommendation to expand ECP to rest of country</li> </ul>	Programmes	<ul style="list-style-type: none"> <li>297 Master Trainers trained who in turn trained 2,264 trainers at district level</li> <li>EC introduced in all 64 districts of Bangladesh.</li> <li>40,009 service provider trained on ECP</li> <li>2,134 NGO service providers were trained from the country</li> <li>Many service delivery NGOs including NSDP (USAID funded NGOs) included ECP in their service.</li> </ul>
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<b>Stakeholder involvement</b>	<p><b>PRE-RESEARCH:</b> Project Advisory Committee, chaired by Directorate General of FP, monitored and reviewed project activities. Other members of the committee were ICDDR,B; BIRPERTH; Pathfinder International, John Snow, Inc. and Population Council.</p> <p><b>RESEARCH:</b> Intervention sites included Directorate clinics. Directorate of FP actively participated in implementing the study.</p>										

<b>Communication</b>	<p><b>Target</b> - Directorate General of FP and other policy makers, programme managers, family planning providers, donors, researchers, national and international NGOs and the media.</p> <p><b>PRE-RESEARCH:</b> First workshop on EC in 1997 attended by high-ranking officials, researchers, NGOs and donors.</p> <p><b>RESEARCH:</b> Regular meetings held with government officials to give updates. Research updates disseminated to target audiences.</p> <p><b>POST-RESEARCH:</b> Results presented to MoHFW at the national level including NGOs, donors. Also disseminated at the international level. Media workshop held and articles published in newspapers and magazines to communicate need for EC in Bangladesh and to dispel negative connotations of EC.</p>
<b>Macro Contextual factors</b>	<p>EC is a sensitive issue in an Islamic country. Some policy makers believe the availability of ECP may promote promiscuity.</p>

## **Introducing Emergency Contraception in Bangladesh**

### **Description of Research**

The study was designed to identify the most appropriate and cost effective service delivery model for emergency contraceptive pills (ECP); and test and document how ECP could best be introduced without adversely affecting the use of other family planning methods. An experimental design was developed to test the relative effectiveness of two service delivery models: one providing ECP on demand and the other offering a free prophylactic supply. The study was implemented in 12 health clinics in two districts of Bangladesh. Of the 12 clinics, eight were intervention clinics, while the remaining four were control clinics. The intervention, which consisted of the provision of information and services on ECP, was provided for nine months from March 2001 to November 2001. The study results demonstrated that ECP fulfills a large unmet demand; women who received a prophylactic supply were more likely to use ECP in the event of contraceptive failure or unprotected intercourse, and women accept and are willing to pay for ECP services. The study demonstrated that all categories of health providers, including NGO outreach workers, could be effectively trained to provide ECP services.

Among the two delivery models tested, the model providing ECP as a prophylactic was far more successful in meeting the needs of the clients for ECP than the model which provided ECP on-demand after unprotected intercourse occurred. In the former case, 75 percent of the clients in need, reported use of ECP as compared to 47 percent in the latter case. Further, analysis revealed that the probability of ECP use was more than five times higher if women received the ECP brochure, and almost twice as high if the husband also saw the brochure. However, the country has introduced 'on demand' distribution considering its possible misuse. The same ECP is available in the market at a price that is 4-5 times higher.

### **Research Process**

#### ***Pre-Research Stage***

A workshop was held in 1997, which had four objectives: to share information about EC; to identify scope of EC in the national FP programme; to formulate a plan for future research and action on EC and; to develop a network of organisations for formulating programmes on EC. Findings from the Population Council conducted Knowledge, Attitudes, Practice (KAP) study among health providers on EC was presented at this workshop.

Following the workshop a forum on ECP (FEMCON- Forum on emergency contraception) was initiated in 1998. The Director of Maternal and Child Health (MCH) unit of the Directorate General of Family Planning was selected as Chairman of the forum. The forum continued for 2 years.

At the 42<sup>nd</sup> meeting of the NTC in 1998, it was proposed that technical assistance be sought from Population Council for introduction of EC in the country. The study was initiated at the request of the Ministry of Health and Family Welfare of Bangladesh in 1999. The proposal for the project was presented and reviewed by the National Technical Advisory Committee in 1999, which approved the study and suggested certain modifications prior to the review of the proposal by the National Ethical Committee. Bangladesh Medical Research Council (BMRC) reviewed the proposal and gave ethical clearance in 2000.

Dr. Jebun Nessa Rehman of the UNFPA confirms that the UNFPA had been interested in providing support for the introduction of ECP in Bangladesh all along. The MoHFW advised UNFPA to wait for the results of the Operations Research before it took any action in this regard.

### ***Research Stage***

Operations research was conducted to assess the acceptability and feasibility of the most appropriate and cost-effective service delivery model. The research team consisted of representatives of FRONTIERS, Pathfinder International, John Snow Inc., and the Directorate of Family Planning.

A six-member Project Advisory Committee, chaired by the Director of MCH unit and including representatives of other institutions (Directorate General of Family Planning (DGFP), Pathfinder International, JSI, International Centre for Diarrhoeal Disease and Research, Bangladesh (ICDDR,B), Bangladesh Institute of Research for Promotion of Essential and Reproductive Health and Technologies (BIRPERTH) and Population Council), reviewed and monitored the project activities. The Government's Family Welfare Visitor Training Institutes (FWVTI) were involved with the researchers in implementing, training and monitoring the project activities including performances. The researchers prepared questionnaires, informed consent forms, monitored the ethical issues and visited the fields. The ethical protocols were adhered to throughout the study.

The study developed behavioural change communication (BCC) materials, training materials and designed the training for service providers. Educational brochures on ECP were developed for both providers and clients and these were distributed at both government and NGO settings during the study.

### ***Post Research***

The preliminary findings were presented to the MoHFW before completing the analysis, the idea behind this being the anticipated delay in approval of EC from the Ministry. A preliminary report was also published and distributed to the policy makers and programme managers of the DGFP. The implementation needs of the research results were identified and adequately addressed by the partner organizations including DGFP at workshops, review meetings and seminars held at the national level. The four partners including DGFP finalised the policy recommendations and the final report was published one year later.

Due to the sensitive nature of emergency contraception—which is often confused with abortion—it was key that the study was presented to the press in a factual, un-biased manner. Researchers conducted a press workshop to communicate the need for EC in Bangladesh.

### ***Communication***

The Population Council has been working over the last 7-8 years to introduce ECP in Bangladesh. It held a workshop on EC in December 1997 in collaboration with a local NGO (CWFD) which was attended by many policy makers and programme managers from DGFP including Director General of Health and Director General of Family Planning, NIPORT, NGO representatives (ICDDR,B, BWHC, BAPSA, Nari Pokkha, BIRPERTH, BRAC, BNPS, CWFD, FPAB, FPSTC, FPCST, FPMD, PRDA, Marie Stopes Clinic Society, Plan International, JSI, EngenderHealth, Pathfinder International, Population Council, SMC), media representatives, Pharmaceuticals (Medimpex), John Hopkins University, WHO, UNFPA, UNICEF, UNDP, CIDA, USAID, and several international experts (from India, Vietnam and USA). Prominent gynaecologists in the country were also involved as resource persons. The Secretary, Ministry



of Social Welfare, attended as the chief guest. Organisations, particularly those working for women, were invited to attend the workshop.

Researchers held regular meetings with officials of DGFP at the national and field level as well as implementing NGOs while the project was underway.

The study findings were presented to MoHFW, NGOs and donors at the national level. The results were also disseminated internationally. The researchers held a special workshop for the media in order to communicate the importance of EC in Bangladesh. Articles were also published in magazines and newspapers on this and to dispel negative connotations of EC.

### **Macro contextual factors**

A small fraction of policy makers believe that the availability of ECP may increase promiscuity. This has also been evident during the training of programme managers in other divisions. However, as this is a national programme, nobody has enough influence to oppose it. Experiences from scale up in Dhaka divisions revealed that financial constraints are a major problem during scale up. As the government was dependent on UNFPA and technical assistance from Population Council, due to overlapping of the financial year the programme was delayed.

Experiences also revealed two other important barriers in implementing the ECP programme. One is the provider's willingness to give choices for using ECP during counselling. It has been reported that some providers, namely the Family Welfare Visitors (those performing menstrual regulation/abortion) are less interested in providing information about ECP to clients as they fear their income may decline. Another barrier is the price of the product. As all FP commodities are free of charge in Bangladesh, many programme managers and service providers reported that EC use rate is not at the expected level due to the price of the product.

EC is a sensitive issue in an Islamic country. To create supportive environment for introduction of EC, researchers used several ways to communicate research findings including: articles in the magazines and newspapers, and national presentations, media presentations, workshops and seminars. All highlighted ECP as an important health intervention.

### **Scale Up/Application**

Once the study findings were presented to the Ministry, UNFPA offered to provide support to the government for the introduction of ECP, which was accepted. Dr. Rehman confirms that as per normal UNFPA procedures, the Government of Bangladesh provided a demand letter to the UNFPA indicating the amount of emergency contraceptive supplies required, which were then purchased by the UNFPA through their headquarters. With the government's approval, UNFPA also provided financial support to organize training programs for service providers. Dr. Rehman states that in addition to these the UNFPA also monitored the implementation of ECP activities. The Government of Bangladesh also asked FRONTIERS to provide continued technical assistance during the project scale-up. The government gave its approval to the BCC and training materials developed during the study period, and these were also used during the scale up phase.

According to Dr. Rehman, ECP was priced based on the study recommendations. It was seen that women were willing to pay for these if available and the majority (80%) agreed to pay ten taka. The Ministry set the minimum price at 8 taka.

Involvement of the government throughout the research process—from conceptualisation through the study design, implementation and analysis—was crucial to the utilisation of the study’s findings. The following strategic steps were key to this involvement: involving the Directorate as the principal partner and implementer; ensuring the engagement of the Director General of Family Planning at all stages of the work; appointing him to chair the Project Advisory Committee; holding regular briefings with top programme managers of the Ministry of Health and Family Planning; giving ownership of the study and organising a press seminar to introduce journalists to the reproductive health benefits of EC. In addition, UNFPA was kept informed of the study and thus was ready to participate when the Government approved the scale-up. The two partners in the study, Pathfinder International and John Snow, Inc., were instrumental in extending ECP services through the NGOs they work with. *S. Shahnaz (formerly Pathfinder)* confirms that this was done in full knowledge and support of the Bangladesh government right from the national level down to the field. The other important facilitating factor was the USAID’s inclusion of expansion of ECP services by NGOs in their Request for Application.

### ***Evidence base***

The project results and lessons learned from scale up were presented to Population Council in Washington, DC and New York in May 2004, where USAID representatives were present. The findings were also presented at international seminars (APHA), and at regional international seminars (the Philippines and India), the Annual Meeting of the International Consortium for Emergency Contraception in New York in September 2004, and the annual meeting of the Asia Pacific Network On Emergency Contraception (APNEC) in November 2004.

### ***Policy***

The Government of Bangladesh introduced ECP into family planning programmes in 2001. NGOs in the country also revised their policies to include ECP in the services they provide. In 2004, the Government recommended that ECP be expanded to the rest of the country.

### ***Programmes***

ECP has been introduced throughout the country in phases. The scale up programme was started from October 2003 to cover a population of 45 million. The first phase was implemented in 17 of the country’s 64 districts (809 trainers; 14007 service providers). Training of master trainers began in January 2003. The 46 master trainers at the central level trained 485 trainers at the district level who in turn trained all the service providers and their supervisors at the upazila (sub-district) level (a total of 14,219). In addition, the NGOs, DGFP and Population Council together trained 1,050 providers from 72 NGOs. Many NGOs included ECP in their services.

Dr. Rehman states that the UNFPA felt that ECP should be available through a prophylactic approach. However, due to concerns of possible misuse it is being provided on demand. The service delivery is being monitored and the Population Council is collecting feedback from the clients, which will help get a better perspective and determine future actions.

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1. Waris, Syeeda Tazneen and Sharif Mohammed Ismail Hossain. 2005. Master Trainers Training on Emergency Contraceptive Pills (ECPs) of the Government Officials of Rajshahi, Khulna, Sylhet and Barishal and Chittagong Divisions. Dhaka, Bangladesh: Directorate General of family Planning.

2. Khan, ME and Sharif Mohammed Ismail Hossain. 2005. Expanding ECP in other divisions: experiences from training of trainers in Bangladesh. *Research Update 5 (In progress)*. Dhaka: Population Council/FRONTIERS.
3. Khan, ME and Sharif Mohammed Ismail Hossain. 2004. Scale up Emergency Contraceptive Pills Program in Bangladesh: Experiences from Program Implementation (unpublished). *Research Update 4*. Dhaka: Population Council.
4. Khan, ME and Sharif Mohammed Ismail Hossain. 2003. Introducing Emergency Contraceptive Pills in Bangladesh: Lessons Learned and Its Policy Implication. *Research Update 3*. Dhaka: Population Council/FRONTIERS.
5. "Clients and providers see benefits of emergency contraception pills," *FRONTIERS OR Summary* No. 48. Washington, DC: Population Council, 2005.
6. Khan, M.E., Sharif Mohammed Ismail Hossain, and Moshir Rahman. 2004. "Introduction of emergency contraception in Bangladesh: Using operations research for policy decisions," *FRONTIERS Final Report*. Washington, DC: Population Council.
7. Hossain, Sharif Mohammed Ismail, Bashra Parveen and Bishnupada Dhar. 2003. Introducing Emergency Contraceptive Pills (ECP) in Bangladesh: Sharing of Experiences and Lessons Learned. A Proceeding (unpublished), Dhaka, Bangladesh: Population Council and Directorate of Family Planning.
8. Khan, M.E. and Sharif Mohammed Ismail Hossain. 2002. "Training Service Providers on Emergency Contraception: Lessons Learned from an OR Study." *FRONTIERS Research Update* No. 2. Dhaka, Dhaka, Bangladesh: Population Council.
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10. Hossain, Sharif Mohammed Ismail and Syeeda Nahid Mukit Chowdhury 1998. "Proceedings on Emergency Contraception Workshop." Dhaka: Population Council.
11. Training manuals
  - a. Hossain, Sharif Mohammed Ismail, M. E. Khan, Moshir Rahman, Jahiruddin Ahmed, Mirza A. H. M. Bareque and Bishnupada Dhar. 2004. *Emergency Contraceptive Pills: A training Manual (Bengali)*. Dhaka: Population Council/FRONTIERS and Directorate of Family Planning.
  - b. Hossain, Sharif Mohammed Ismail, M. E. Khan, Moshir Rahman, Jahiruddin Ahmed, Mirza A. H. M. Bareque and Bishnupada Dhar. 2003. *Emergency Contraceptive Pills: A Training Manual (English)*. Dhaka: Population Council/FRONTIERS and Directorate of Family Planning.
  - c. Hossain, Sharif Mohammed Ismail, M. E. Khan, Moshir Rahman, Jahiruddin Ahmed, Mirza A. H. M. Bareque and Bishnupada Dhar. 2004. *Flipchart on Emergency Contraceptive Pills (Bengali)*. Dhaka: Population Council/FRONTIERS and Directorate of Family Planning. This has been using by the government and NGOs for the whole country.

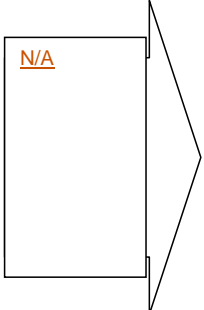
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### Sex Work and Migration in Cambodia: The Dangers of Oversimplification

Factors	Pre-research	Research	Post-research	Scale-up Activities	Application/Utilisation
<b>Research Process</b>	<ul style="list-style-type: none"> <li>Research topic identified by researcher based on data emerging from a larger study to evaluate a MSF social intervention.</li> </ul>	<ul style="list-style-type: none"> <li>Analysis of data collected for evaluation of MSF social intervention</li> <li>Data collected by local MSF team</li> <li>'Trafficking and sex work' analysis done after evaluation concluded</li> <li>Ethical implications considered throughout data collection stage</li> </ul>	<ul style="list-style-type: none"> <li>Several articles based on the findings were written for peer-reviewed journals.</li> </ul>	<div style="border: 1px solid black; padding: 5px; display: inline-block;">N/A</div> 	<b>Evidence Base</b> <ul style="list-style-type: none"> <li>Conference presentation</li> <li>Articles in various journals for academic and wider audience</li> <li>Websites citing the study: ID21; Reproductive Health Outlook;</li> <li>Study contributed to evidence base; similar findings from study in Mali</li> <li>Findings used by OHCHR</li> </ul>
<b>Stakeholder involvement</b>	<ul style="list-style-type: none"> <li>Researchers maintained a low profile as the evaluation dealt with Vietnamese immigrants who are very unpopular in Cambodia</li> <li>Since this was a retrospective study, there was no stakeholder involvement at any stage.</li> </ul>				<b>Advocacy</b> <ul style="list-style-type: none"> <li>Findings picked up by anti-trafficking groups and individuals interested in issue of trafficking or sex work and migration more broadly</li> <li>Increased debate on issue of trafficking and sex work</li> <li>Increasing number of NGOs and think-tanks studying issue from this different perspective</li> </ul>
<b>Communication</b>	<p><b>Target audiences:</b> Groups concerned with sex workers' health and rights; organisations interested in migration and health; institutions involved in broader, international policy debates around trafficking, sex work, HIV programming; sex workers.</p> <p><b>POST-RESEARCH:</b> Conference presentation</p> <ul style="list-style-type: none"> <li>Articles in various journals for academic and wider audience</li> <li>Websites citing the study: ID21; Reproductive Health Outlook; Global Commission on International Migration;</li> <li>Amnesty International - in their Bulletin (June 4, 2004).</li> </ul> <ul style="list-style-type: none"> <li>Citation on the website of Global Commission on International Migration</li> <li>Citation in Amnesty International's bulletin (June 4, 2004)</li> </ul>				<b>Policy</b> <ul style="list-style-type: none"> <li>Findings included in WHO toolkit on sex worker projects</li> <li>Scarlet Alliance (Australia) used results of study in policy debate over sex worker laws</li> <li>Study referred to by OHCHR</li> </ul>
<b>Macro Contextual factors</b>	<ul style="list-style-type: none"> <li>US Government's anti-trafficking stand; no funding provided to programmes that are seen to be sympathetic towards sex workers</li> <li>Growing international focus on sex trafficking</li> </ul>				

## Sex Work and Migration in Cambodia: The Dangers of Oversimplification

### Description of Research

This retrospective study was based on a wider evaluation of a social intervention for sex workers in the brothels of Svay Pak village in Phnom Penh, Cambodia. The evaluation was conducted by Population Council's Horizon's programme in collaboration with Cambodia Researchers for Development and Médecins Sans Frontières (Belgium/Holland/Switzerland). This research was driven by existing policies on trafficking and sex work, and looked at the impact of such policies at the community level. While trafficking of sex workers can by no means be condoned, the study found that policies formulated to address these issues can end up causing more harm to the very people they are meant to protect because of the way they are interpreted and implemented. Also, what may appear to be trafficking might not in actuality be the case. While there has been no obvious or measurable impact of this research, there has since been a growing body of literature that challenges the mainstream approach to sex work and trafficking.

### Background to Research

The retrospective study by J Busza was carried out between 2002 and 2004 and looks at the issue of trafficking and sex work. The study is based on data collected during an evaluation ~~by Population Council's Horizon's programme (Bangkok office)~~ of a community-based programme for sex workers implemented by Médecins Sans Frontières (Belgium/Holland/Switzerland), in Svay Pak village, Phnom Penh, Cambodia. The MSF clinic in Svay Pak initially provided only primary health care and health promotion to the sex workers, and the evaluation aimed to show that by adopting a holistic, participatory approach to working with sex workers, taking into account their own priorities, it would be possible to develop a more sustainable and appropriate HIV prevention programme.

During the period of evaluation, which took place between 2000 and 2002, trafficking was not a prominent international issue. While there was concern about the system of migration and debt-bondage that the sex workers entered into, a bigger concern was the sex workers' vulnerability to HIV, and the growing epidemic within Cambodia that appeared to be driven by commercial sex. The government's fears that sex work would contribute to the rapid spread of HIV to the general Cambodian population were the primary reason behind Cambodia's 100% condom policy.

Over time, trafficking issues came to the limelight and Cambodia, in particular, began to attract the attention of the world. The researcher was increasingly concerned that the international concern about trafficking was very simplistic in its approach to the issue. The catalyst that led to this study was, after the election of President George W Bush, when a Senate Hearing Committee looked at USAID's funding of 'immoral' projects ie tax payer's money going towards funding projects that were deemed to be against the morals of the US government. By this point the Horizons-MSF evaluation of Svay Pak had been completed.

The US government began to actively address international trafficking and there was increasing attention to trafficking in the media as well. The researcher decided to do a retrospective analysis of data collected from Svay Pak (both qualitative and quantitative data collected on the subject), looking specifically at how the Vietnamese women got to Svay Pak and whether or not that could be considered as trafficking.

## Research Process

### *Research Stage*

In order to have an understanding of what was going on, the evaluation research team began to look into the system of debt-bondage and how the Vietnamese sex workers were brought into Cambodia. Trafficking gradually became a 'hot' topic internationally, though the [evaluation](#) research team was not explicit about wanting to address the issue of whether or not the women at Svay Pak were trafficked. J Busza had a growing interest in the subject of trafficking and sex work and so developed questions related to this, which were administered to the study population during the course of the evaluation. Also, as the data collection team was based in the village, they got to know the sex workers well and picked up information during the course of their stay that helped inform the research on trafficking. Focus group discussions and in-depth interviews were held with the sex workers.

The fact that the sex workers were illegal immigrants, was not a point of sensitivity and they were willing to discuss the circumstances behind their migration; "trafficking" itself was not a local concept. Only those willing to speak were interviewed and they were given the opportunity to refuse answering any questions, though this tended to happen only with regard to their working conditions.

The fieldwork for the evaluation was carried out by three MSF staff (two Cambodian and one Vietnamese women), none of who were from Svay Pak village, though for the duration of the research they were worked full-time in the village.

Ethical considerations were at the forefront throughout the study. The research team did a lot of work around informed consent to ensure that no one participated against their will and that the research itself would not have any negative impact(s) on this potentially vulnerable group. Participatory workshops were held so that sex workers could develop their own informed consent procedure.

While the relevant Cambodian authorities were informed of the Horizons-MSF evaluation, they had limited involvement in it. The researchers maintained a low profile as the study dealt with Vietnamese immigrants (mostly illegal) who are very unpopular in Cambodia. The evaluation team had no direct interactions or involvement with the local police.

During the course of the evaluation, the researchers considered the sensitivity of findings relating to trafficking of sex workers. The only aspect that was thought to be controversial at that point was the promotion of female condoms, something the Cambodian government was sceptical about, due to the relative cost of female condoms compared to male condoms.

### *Post-Research Stage*

The analysis on trafficking and sex work data was carried out with the initial aim of sharing the findings with an academic audience.

Since then, with increasing debate on the subject of trafficking, other methods of disseminating the research findings are being explored in order that a wider audience has an understanding of the nuances of international trafficking and so that simplistic ideas related to trafficking are dispelled. The concern of the researcher is that a blinkered approach towards trafficking may do more harm to the sex workers than good.

## Scale Up/~~Scale-Up~~ and Application

### *Evidence Base*

An article was published in the British Medical Journal on the different aspects of international trafficking, and a longer version in *Health and Human Rights*. A paper was also presented at a Population Association of America Annual Conference, as a result of which several groups have contacted the researcher to comment on study protocols. In addition, several articles based on the findings have been published in other peer-reviewed journals (see Publications list).

The researcher is not aware of any uptake of findings by the Cambodian government, other governments or international bodies, but knows that the findings have been picked up by anti-trafficking groups. A study on child trafficking in Mali has also revealed many parallels with this study.

Scarlet Alliance, the Australian Sex Worker Association representing issues of sex workers at the national level, feels that that as research methodology for this study used existing, trusted service providers to sex workers as the avenue for contacting participants and the interviewers themselves were as close to peers as possible (with the exception apparently being current engagement in sex work), the findings are likely to be more accurate. The acknowledgement that the majority (94%) of sex worker participants in the study had consented to engage in sex work under a debt bondage contract in a brothel setting matched Scarlet Alliance's understandings of the voluntary nature of migratory contract sex work in Australia and the findings contributing to their improved understanding of the issues and possible ways forward.

J Sanghera of the OHCHR says that the human rights impact of anti-trafficking interventions is an issue that OHCHR has been actively addressing over the last 3 years at the implementation level. The links between sex work and trafficking are only one of the many dimensions looked at by OHCHR, and this has been amplified though a ten country study in Eastern Europe, undertaken jointly by OHCHR, UNICEF and ODIHR. Three updated versions of this study were published between 2003 and 2005. A study based on the 'Do No Harm' principle to examine the human rights impact is currently underway. This looks at the legal and programmatic interventions of various stakeholders. The research in Cambodia by J. Busza is very much along the same lines as the activity and concerns of OHCHR. The findings of the study are certainly valid and support similar conclusions generated from research in other parts of the world. Such research findings as well as OHCHR's own evidence base will assist the High Commissioner in devising a strategy at some point in the near future in addressing the serious harms that are occurring worldwide, in the name of combating trafficking.

### *Advocacy*

~~J-Busza~~ The researcher has since been contacted by several journalists as well as think-tanks in the US and NGOs who are studying the issue from different perspectives and trying to get more accurate estimates based on findings from this research. There has also been growing opposition to the US government's trafficking stance. Similar findings by NGOs from their programmes are being shared with the researcher. There has been a recent article in the Thai newspaper challenging international NGOs and UN agencies for inflated trafficking statistics. At the same time, following the US government's crackdown on programmes that are seen to be sympathetic towards sex workers, anti-trafficking articles have appeared in several US newspapers.



Scarlet Alliance has incorporated some of the understandings from the findings into contributions made to the debate around the provision of services to migratory sex workers, and to policy forums such as a videoconference held by the US Consulate on anti-trafficking (verbal contributions). It intends to circulate J Busza's paper to other networks of service providers working with sex workers.

## **Policy**

Scarlet Alliance came across one of the articles by J Busza and felt the findings were easy to apply to the Australian setting and that it echoed their observations and understandings of the impacts of legislation. They incorporated aspects of the article, such as trafficking and its association with increased health risks, including STIs and HIV/AIDS, in a submission to the Senate Legal and Constitutional Legislation Committee<sup>1</sup> in order to show how anti-trafficking interventions may result in increased risk of harm and exploitation, increased reliance on corrupt officials and clandestine routes of travel, and reduced access to services in destination countries. M McMahon of Scarlet Alliance says that while no specific recommendations were made by the Committee to address the issues raised, the Committee noted the issues in their report in a section titled "Other issues", and recommended that the provisions of the Bill be subject to further and wider consultation, and noted "an inadequate process of consultation" with key stakeholders, including sex worker groups. The Bill has since been amended, though the specific concerns raised by Scarlet Alliance were not taken on board adequately.

<sup>1</sup> The Senate Committee was formed in order to collect information on the potential impacts and outcomes of proposed amendments to Australia's Criminal Code Amendment Trafficking in Persons Offences Bill (2005)

## **PUBLICATIONS**

1. Busza J, Xakha HE, Da LS, Saron U. "Petals and thorns: the dilemmas of PLA and debt bondage", *PLA Notes* 40 (Feb 2001)
2. Busza J, Schunter BT, "From competition to community: participatory learning and action among young, debt-bonded Vietnamese sex workers in Cambodia", *Reproductive Health Matters*, Vol. 9, No. 17 (May 2001)
3. Busza J, "Sex Work and Migration: The Dangers of Oversimplification – A Case Study of Vietnamese Women in Cambodia", *Health and Human Rights*, Vol. 7, No. 2 (2004)
4. Busza J, "Participatory research in constrained settings: Sharing challenges from Cambodia", *Action Research*, Vol. 2(2): 191-208 (2004)
5. Busza J, Baker S, "Protection and participation: an interactive programme introducing the female condom to migrant sex workers in Cambodia", *AIDS Care*, Vol. 16, No. 4, pp: 507-518 (May 2004)
6. Busza J, Castle S, Diarra A, "Trafficking and Health", *British Medical Journal*, Vol. 328 (5 June 2004)

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### Increasing the Uptake of IUCD in Nepal

Factors	Pre-research	Research	Post-research	Scale-up Activities	Application/Utilisation				
<b>Research Process</b>	<ul style="list-style-type: none"> <li>Research question identified by Sunaulo Parivar Nepal (SPN)</li> <li>Relevance of research question discussed and agreed with MoH, Nepal</li> <li>Research backed by Government of Nepal</li> <li>Ethics standards approved by MoH</li> <li>Funded by DFID and DFID Nepal</li> </ul>	<ul style="list-style-type: none"> <li>Study designed to be replicable within Nepal at a sustainable cost</li> <li>Qualitative study conducted</li> <li>Local researchers employed throughout the study</li> <li>Community Health Volunteers given 2 days intensive training on IUCD and incentives.</li> </ul>	<ul style="list-style-type: none"> <li>Findings presented at workshop shortly after conclusion of study.</li> <li>Local press were invited to the workshop</li> <li>Final findings were well received by the stakeholders.</li> </ul>	<ul style="list-style-type: none"> <li>SPN rolled out study for additional 12 months in a larger number of clinics.</li> <li>Leaflets and posters designed on IUCD issues for women</li> </ul>	<table border="1" style="width: 100%;"> <thead> <tr> <th style="background-color: #cccccc;">Evidence Base</th> </tr> </thead> <tbody> <tr> <td> <ul style="list-style-type: none"> <li>Findings presented at international conferences</li> <li>Study on male involvement in FP/RH carried out based on this study</li> </ul> </td> </tr> <tr> <th style="background-color: #cccccc;">Practice</th> </tr> <tr> <td> <ul style="list-style-type: none"> <li>IUCD use increased dramatically as confirmed by K Thapa, former Director, SPN</li> </ul> </td> </tr> </tbody> </table>	Evidence Base	<ul style="list-style-type: none"> <li>Findings presented at international conferences</li> <li>Study on male involvement in FP/RH carried out based on this study</li> </ul>	Practice	<ul style="list-style-type: none"> <li>IUCD use increased dramatically as confirmed by K Thapa, former Director, SPN</li> </ul>
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<b>Stakeholder involvement</b>	<p><b>Stakeholders:</b> Opportunities and Choices, DFID, DFID Nepal, SPN</p> <p><b>PRE-RESEARCH:</b> Study design and protocol developed in consultation with DFID Nepal and MoH, His Majesty's Government of Nepal</p> <p><b>RESEARCH:</b> Nepalese study coordinator acted as point of contact for all stakeholders and kept them informed of research progress. MoH Communication Group involved in ensuring that the marketing campaign met Government standards.</p>								
<b>Communication</b>	<p><b>RESEARCH:</b> Quarterly project reports hand-delivered to DFID Nepal and Family Health Division, MoH, Nepal. SPN developed an effective radio programme.</p> <p><b>POST-RESEARCH:</b> Final report produced and disseminated to all stakeholders. Also posted on Opportunities and Choices website</p>								
<b>Macro Contextual factors</b>	<ul style="list-style-type: none"> <li>Due to the tense political situation in Nepal, which restricts movement within the country, the study design had to be altered. As a result, plans to deploy mobile sterilisation camps were dropped.</li> <li>No further scale-up activities have been possible due to continuing unrest in Nepal.</li> </ul>								

## **Increasing the Uptake of IUCD in Nepal**

### **Description of Research**

This research is a joint study between Opportunities and Choices – a DFID funded Knowledge Programme, Marie Stopes International (MSI) and their partner, Sunaulo Parivar Nepal (SPN). The project was funded by DFID through Opportunities and Choices and DFID Nepal. The study has three main elements employing different research strategies. The first is the use of focus group discussions to inform the social marketing campaign to promote the use of the IUCD. The second is the training of female community health volunteers to talk to women in their villages about the IUCD. The final component is the provision of IUCD in clinics in three districts and following up those women who adopted the IUCD. The study was conducted over a 12-month period in three districts of Nepal and concluded in 2003.

### **Research Process**

#### *Pre-Research Stage*

The original concept for this research came from observations made by SPN, MSI's partner in Nepal. It was noticed that the IUCD attracted very little attention and uptake. The mainstay of family planning in Nepal was female and male voluntary surgical sterilisation, which was carried out both in static clinics and mobile camps. Alternatives needed to be introduced to the method mix so that women and couples have a wider choice of contraceptives.

SPN learnt of the Opportunities and Choices programme through MSI and contacted them to discuss the research idea, following which Opportunities and Choices prepared the project proposal. The partners then together approached DFID. Discussions were also held with DFID Nepal. Initially they agreed in principle to the research but asked for changes to the proposal before providing in-country funding. DFID Nepal's main concern was that any study that was carried out over the course of 12 months should be replicable within Nepal at a sustainable cost, after the study had been completed. The changes made to the research proposal reflected these concerns and eventually DFID Nepal were satisfied. On obtaining DFID Nepal's approval, SPN got approval from His Majesty's Government of Nepal. The Minister of Health for Nepal was also keen to ensure that sustainable outcomes resulted from this study. The final design incorporated the requirements of all the partners.

Policymakers in the government and NGOs were the target audience for this study. In order to identify target audiences, discussions were held with several different organisations within Nepal. Discussions were also held with the Family Health Division (FHD) of the Ministry of Health in Nepal. From these it was found that there was also concern within the Ministry about the low use of the IUCD. They had commissioned a study in 1996 to investigate the reasons behind the poor uptake; from this they discovered a number of issues, which included provider bias, poor availability and accessibility, and low numbers of trained providers. The Minister of Health, Dr Pathak, gave Government backing to this study.

The protocol of the study was continually updated during initial discussions with the MoH, DFID Nepal and SPN until all parties were happy with the content. The indicators for the study were clearly stated from the start of the project in the final protocol, which is owned by the MoH and DFID Nepal. The indicators were the sites of the study and the outcomes, the main outcome being the number of women who continue and discontinue with the IUCD at the end of the study period and the reasons for both these different courses of action. The indicators did not change during the study period.

### ***Research Stage***

Part of the study involved developing appropriate messages for women in Nepal, achieved using the results of the qualitative research to inform the social marketing campaign to meet their needs. The MoH's communication group were involved in finalising the marketing campaign to ensure it met the Government's standards. Their involvement meant that at the end of the study, the campaign could be rolled out to the country as a whole. SPN developed an effective radio programme during the project period.

A quarterly project report was hand delivered to DFID Nepal and the Family Health Division of the MoH by the Nepalese study coordinator who oversaw the research in country. The coordinator was a dedicated member of the research team, who liaised with all parties including the clinic team, the female community health volunteers, the head office at SPN (where he was stationed), the MoH, and DFID. Having one dedicated member of the team employed in this process and readily identifiable by the different organisations meant that he was easily contactable by them. A constant update of the research during its progress to the interested parties meant that their interest was maintained.

The research team also contacted the Family Planning Association of Nepal (FPAN) and UNFPA Nepal. The FPAN was involved directly in one study district by providing their female community health volunteers and they also provided support for the nurse in that region. UNFPA had no direct involvement although the research team did meet with them beforehand to discuss the research that they had performed in Nepal that was related to this study. UNFPA had themselves been looking at ways of increasing the uptake of the IUCD.

### ***Post-Research Stage***

On completion of the study, a workshop was held and attended by members of the Government and NGOs. The local press was also invited to cover the workshop and its findings. The stakeholders received the findings very well and all findings and materials were available for stakeholders to refer to. The release of the findings was well timed as it was presented shortly after the conclusion of the study and so the results were very relevant.

The research team made policy recommendations to all groups who had any involvement in the provision of the IUCD to women in Nepal. The recommendations were:

- Formulate national policy with regards to health as well as donor agencies that wish to work in Reproductive Health and Sexual Health in Nepal.
- Increase promotional activities on Family Planning.
- Promote IUCD especially by elimination of misconceptions to providers and clients and recognise the role of men in enhancing the reproductive health status of women in Nepal.
- Involvement of men in decision-making, service provision and development of IEC materials.
- Promotion of female health professionals to reduce the obstacle of male providers as potential barriers to uptake.
- Adopt a policy to fulfil unmet demand for family planning and to promote small families.
- Incorporate central issues of IUCD Study while revising IUCD curriculum.
- Increase access to a broad range of family planning methods.

## **Communications**

A report based on the study findings was produced which was disseminated to all the stakeholders. The findings have been posted on the Opportunities and Choices website. The qualitative research was presented at the Population Association of America; the IUCD study findings were presented at the British Population Association Conference, at a University of Southampton postgraduate meeting, and at the Blair-Bell Medical Conference.

## **Macro Contextual Factors**

The political situation in Nepal has created a number of barriers, which included restrictions to movement within the country. The study had to be changed in design because of this problem, which meant mobile sterilisation camps were not being deployed. It has also been difficult to implement changes at the ground level since the study concluded due to mobility restrictions.

## **Scale-Up/Application**

Former SPN Director K Thapa states that budgetary constraints have limited the extent to which the study recommendations could be implemented within Nepal. The study was rolled out, however, for a further 12 months by SPN and covered a larger number of clinics, using the unspent funds left in the original budget. Increase in demand for IUCDs, less complications with its use and client satisfaction, paramedicalisation, less manpower required for rollout, and an affordable price for the clients were factors that enabled further expansion of the study. Leaflets were designed for the women to cover all issues relating to the IUCD that may affect her. The positive messages conveyed through the posters helped increase client numbers dramatically as confirmed by K Thapa.

An important factor that facilitated the progress of the study and uptake of findings is the common ground that existed between the Opportunities and Choices team and its counterparts, which smoothed the process, for instance shared educational backgrounds eased tensions and increased the trust between researcher and policy maker.

The development of good relationships with the Government and NGOs has laid the path open for a smooth transition from research into policy change. The involvement of major organisations from the very beginning, in the development of the research proposal and its implementation, has been vitally important in allowing the research to progress well. The receptiveness of all involved parties from the very outset and their continued input will allow smooth dissemination of the results.

## ***Evidence Base***

Further research on male involvement in family planning and reproductive health was later carried out by Dr. Ram of Kathmandu University for the University of Southampton, which was based on findings from the IUCD study.

## ***Policy***

As far as SPN is aware, no policy changes with respect to the IUCD have been made by the Government or are expected in the near future.

### ***Practice***

SPN was unable to carry out any advocacy work due to lack of extra funding. However, the demand for IUCDs has risen due to the impact of the research done in SPN clinics.

### **PUBLICATIONS**

1. Developing and testing strategies for increasing awareness of the IUCD as a contraceptive option - Report of workshop held on 18-20 February 2004. FRONTIERS and Opportunities and Choices Research Programme.
2. Factsheet 18: Barriers to Intrauterine Contraception in Nepal. Opportunities and Choices, Marie Stopes International
3. Factsheet 19: Intrauterine Contraception in Nepal: Cohort Study. Opportunities and Choices, Marie Stopes International

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**Randomised Control Trial of Participatory intervention with women’s groups on birth outcomes in Makwanpur, Nepal**

Factors	Pre-research	Research	Post-research	Scale-up Activities	Application/Utilisation
<b>Research Process</b>	<ul style="list-style-type: none"> <li>Research team unaware of any other RCT of a community intervention</li> <li>Research Team: Mother and Infant Research Activities (MIRA), Institute of Child Health and Institute of Development Studies</li> <li>Ethical approval from the Ministry of Health (MoH), Nepal Health Research Council and the ethics committee of the Institute of Child Health and Great Ormond Street Hospital for Children, UK.</li> <li>Consent from District Development Committees (DDC) to undertake research in their area.</li> <li>MIRA has established links with the MoH.</li> </ul>	<ul style="list-style-type: none"> <li>Cluster randomized control trial</li> <li>Research implemented by Nepalese research team (MIRA)</li> <li>Ethical protocol adhered to.</li> </ul>	<ul style="list-style-type: none"> <li>Independent verification of the data by the Data Safety Monitoring Board.</li> <li>Results fed back to local people at meeting jointly convened with MoH in Kathmandu prior to publication.</li> <li>Additional papers written addressing response to initial publication</li> </ul>	<ul style="list-style-type: none"> <li>Prior to the research, DDCs agreed to continue to pay facilitators salaries</li> <li>Paper on sustainability and scalability being drafted</li> <li>Paper on cost effectiveness being published.</li> </ul>	<p><b>Evidence Base</b></p> <ul style="list-style-type: none"> <li>Two publications in the Lancet</li> <li>Policy implications paper currently being drafted.</li> <li>5 new trials underway in Bangladesh, India (urban and rural areas), Malawi and Nepal</li> </ul> <p><b>Policy</b></p> <ul style="list-style-type: none"> <li>Document examining scalability and sustainability being developed for MoH</li> <li>Policy within Health Sector Reform of 2004 to convert the MCH into Assistant Nurse Midwife through training</li> </ul> <p><b>Programmes</b></p> <ul style="list-style-type: none"> <li>In discussion with the DFID funded Safe Motherhood programme.</li> </ul> <p><b>Practice</b></p> <ul style="list-style-type: none"> <li>Research team has been contacted by an Indian bank after seeing article about the study in the Lancet to roll out the intervention via micro credit groups.</li> </ul>



<b>Stakeholder involvement</b>	<p><b>Stakeholders:</b> Ministry of Health, NGOs, representatives of United Mission to Nepal, CEDPA, JSI, SCF, UNICEF, national safe motherhood representatives and, local and district development committees.</p> <p><b>PRE-RESEARCH:</b> Pre-research workshop held where research design was finalised</p> <p><b>RESEARCH:</b> Steering committee meetings consisting of the research team, a MoH official, and MIRA Executive Committee members.</p>
<b>Communication</b>	<ul style="list-style-type: none"> <li>• Meetings held every four months between the research team and the district development committees.</li> <li>• Steering committee meetings every four months</li> <li>• National dissemination workshop in Kathmandu</li> </ul>
<b>Macro Contextual factors</b>	<ul style="list-style-type: none"> <li>• Political instability; research area now predominantly under Maoist control</li> <li>• Pressure not to downplay the current international maternal and newborn health policy focus on health service strengthening.</li> </ul>

## **Randomised Control Trial of Participatory intervention with women's groups on birth outcomes in Makwanpur, Nepal**

### **Description of Research**

This DFID funded research used a randomised cluster control trial methodology to examine the impact of community participation on neonatal and maternal mortality. The intervention consisted of a facilitator, who convened a woman's group meeting once a month. The facilitator worked with women to identify local perinatal problems and develop strategies to address these problems. The problems and strategies varied in the different clusters. The health services were strengthened in both the control and intervention areas. The study found that neonatal mortality was 30% lower in the intervention area compared to the comparison area. The researchers believe the impact of the intervention came about through a combination of improved hygiene practices and care-seeking behaviour, not limited to government health services, but also pharmacies. Empowerment of women and the social capital of the groups may also be important in influencing care practices and care-seeking.

### **Research Process**

#### ***Pre-Research Stage***

The research came out of a need to test the impact of community participation in health with hard outcomes, for example mortality, as opposed to soft process outcomes, for example increased care-seeking behaviour. This was seen to be especially important for health issues that can only be solved in the home, for example maternal and newborn health. Prior to the research starting but after provisional funding approval had been obtained, a workshop was held in Kathmandu to discuss the research design. The research team drew on the experience of UNICEF in country whilst designing the study as confirmed by S Clapham, DFID Nepal.

Dr. R Thapa, the Hon. Senior Policy Adviser, MoH first heard of the research when attending the PESON International Conference in Kathmandu in 2003, where Prof. D. S. Manandhar and Prof. A Costello made presentations. She later read about it in an article in the Lancet, which was based on the study. R Thapa joined the MoH long after the study took off, but as far as she is aware some senior personnel from Health Policy & Research Planning at the MoH and Director General represented the MoH on the study's Steering Committee.

A workshop was held in Katmandu at which the research design was finalised. The following stakeholders attended the meeting: Ministry of Health, MIRA, NGOs, representatives of United Mission to Nepal, CEDPA, JSI, SCF, UNICEF, national safe motherhood representatives and, local and district development committees. The District Development Committees (DDC) were local government in the area prior to the Mao insurgency. The DDCs gave consent for the study to be undertaken within their area and organised meetings to discuss the project with all the village development committee chairpersons in Makwanpur district.

#### ***Post-Research***

The current DFID Health Advisor, Nepal was managing a DFID-funded safe motherhood project during the time of this study and so knew of it in an informal capacity. Following the study and after joining DFID Nepal, the Health Advisor had greater interaction with the research team, primarily the ICH

members who invited her to dissemination sessions and small group visits, which they initiated when they visited Nepal.

### **Communication**

Meetings were held every four months between members of the research team and the DDCs. The steering committee met every 4 months.

### **Scale Up/Application**

#### *Evidence base*

The results of the study have been published in the Lancet and the policy and programme implications of the study are currently being drafted in Nepal. The research team is keen to investigate, and where possible dispel, criticisms of the study in terms of both cost effectiveness and application outside Nepal. An independent researcher has undertaken a cost-effectiveness analysis, and the results will be published in the Lancet shortly.

The research team has found that the first Lancet publication has been misunderstood and the messages taken from the research do not fully reflect the research findings. It is felt that this misunderstanding comes from the prevailing policy context that places great emphasis on better health service provision as the only way in which maternal and newborn mortality can be reduced. Additional publications are planned to dispel the misunderstanding and further disseminate the results.

In order to increase the evidence base, five randomised control trials of a similar women's group intervention are underway in Bangladesh, urban and rural India (Mumbai and Jharkhand), Malawi and a different area of Nepal, Dhanusha. The research partners for these five trials were chosen due to them being champions of newborn health and it is believed that their authority to influence will substantially contribute to subsequent utilisation of the trial results. In India the research partners are development organisations, which it is believed, will facilitate scale up. In addition, a Phase 2 trial is underway in the initial study area where the focus of the intervention has been broadened to include reproductive and child health.

The DFID Health Adviser states that the Safe Motherhood programme has been giving greater attention to increasing access/demand creation since the late 1990s. Considerable documentation attests to the learning related to the supply/demand debate in addressing safe motherhood. From 2002 onwards, addressing increased demand was a well-accepted strategy in the programme. Demand creation is understood in Nepal to mean demanding services as well as non-service interventions – health related behaviors, women's empowerment etc. The research has greatly contributed to this debate and has lent credibility to the need to address demand creation. It adds evidence to the policy that was already in place.

The study suggests that local non-health trained women working as volunteers conduct the essential interventions. In Nepal the already established female community health volunteers (FCHVs) conduct similar work and could, in the safe motherhood community's views, undertake this work – indeed they do some of it anyway. However the FCHVs main focus is on service delivery at community levels (Vit A, assisting with vaccinations campaigns etc). This work is supervised to some degree. A greatly expanded role into health promotion is logical, but DFID Nepal doubt it can be supervised or monitored within the constraints of the health system. Thus scaling up this form of intervention remains a huge challenge.

The policy and safe motherhood plan both address demand creation/awareness creation work. DFID struggles to scale up this cross-sectoral work as it lacks an institutional home. However, the national policy and plan position strengthened health systems are the centre of the national programme. Not only does this draw on international practice but it also reflects national learning. There are many barriers to accessing care, but the perceived quality and distance to a service is a significant barrier. UNICEF and DFID's experience demonstrates that improved service delivery is hugely influential in attracting women to the service.

### ***Policy***

The political situation precludes implementation at present but a document examining scalability and sustainability is being developed for the Ministry of Health.

With this particular intervention there is the difficulty that while it is a health issue, the intervention might be better implemented by sectors other than the health sector, for example the ministry responsible for women's development or through the old DDCs, which had their own development funds.

The MoH intends utilising the results of the study. In fact, the MoH Nepal has been using participatory methods by involving Mothers' Group, and FCHVs (currently more than 46,000) since the late 1960s in promoting basic health care in rural and remote areas. The health outcomes of using such participatory intervention with women's health especially in rural areas have been impressive. The declining trend in infant and child mortality, impressive coverage of both full immunization including polio and Vitamin A including iron foliate should largely be attributed to such participatory interventions in Nepal. Based on such evidence, there should not be any problem for the MoH to scale up women's active participation on promoting birth outcomes. The MoH as part its 2004 Health Sector Reform has already adopted the policy to converting the MCH (one in each Village Development Committee (VDC) – a salaried female health worker with initial 3 months training) into an Assistant Nurse Midwife by upgrading training so that each VDC would have at least one skilled birth attendant which is critical to reducing maternal and neonatal mortality and morbidity.

### ***Practice***

Some of the facilitators in the original study are continuing to work with women on newborn health issues, even in areas where supervision cannot continue due to security problems.

Nepal is committed to the Millennium Development Goals (MDGs). Keeping this in view and the persistently and unacceptably high Maternal Mortality Ratio (MMR) in Nepal, the Senior Policy Advisor, MoH states that local bodies together with the Mothers' Group should be provided with scholarships for recruiting as many willing and qualified young women (preferably daughters-in-law) as possible, for training as Assistant Nurse Midwives from every village of Nepal, particularly remote and rural areas. Placing trained/skilled persons at the place of births (more than 90% of births occur at home) would not only save lives of many women and their babies, it would also empower women with income generating skills. R Thapa also suggests that implementation begins now based on what is already known so that the MMR and NNMR can be reduced and MDGs can be achieved.

## **PUBLICATIONS**

1. Manandhar DS, Osrin D, Shrestha BP, Mesko N, Morrison J, Tumbahangphe KM, Tamang S, Thapa S, Shrestha D, Thapa B, Shrestha JR, Wade A, Borghi J, Standing H, Manandhar M, de L Costello AM

Effect of a participatory intervention with women's groups on birth outcomes in Nepal: cluster-randomised controlled trial. *The Lancet* - Vol. 364, Issue 9438, 11 September 2004, pp: 970-979.

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### Needs Assessment on Adolescent Reproductive Health in Pakistan

Factors	Pre-research	Research	Post-research	Scale-up Activities	Application/Utilisation
<b>Research Process</b>	<ul style="list-style-type: none"> <li>Survey tools designed with partner NGOs</li> <li>Set up norms/ethical considerations</li> <li>Adapted for Pakistan by PAVHNA from an existing ICOMP survey model. Final questionnaire approved by ICOMP.</li> <li>Ethics standards assessed by PAVHNA and RAASTA</li> <li>Funded by ICOMP, Malaysia and UNFPA, New York</li> </ul>	<ul style="list-style-type: none"> <li>Hired local consulting firm 'RAASTA' to conduct research</li> </ul>	<ul style="list-style-type: none"> <li>Findings released 3 months after study completed.</li> <li>Participants accepted findings and made recommendations for future action.</li> </ul>		<p><b>Evidence Base</b></p> <ul style="list-style-type: none"> <li>ARH paper presented at various national and international meetings.</li> <li>Aga Khan University Community Health Sciences Dept used this study as basis for own research.</li> </ul> <p><b>Advocacy</b></p> <ul style="list-style-type: none"> <li>Findings used by PAVHNA in discussion on National Youth Policy through another short project carried out for UNICEF in 2002 and 2003</li> <li>Used by PAVHNA, its NGO partners and ICOMP. PAVHNA advocated on adolescent issues, directing messages at policymakers, gatekeepers at community level and PAVHNA partners.</li> </ul> <p><b>Policy</b></p> <ul style="list-style-type: none"> <li>ARH made part of National RH Programme</li> </ul> <p><b>Programmes</b></p> <ul style="list-style-type: none"> <li>PAVHNA extended adolescent work to all its project areas</li> </ul> <p><b>Practice</b></p> <ul style="list-style-type: none"> <li>Awareness of adolescent boys and girls on RH increased in project area (based on review by MAB Paradigms)</li> <li>Health status of young people has improved.</li> </ul>
<b>Stakeholder involvement</b>	<p><b>Stakeholders:</b> parents, participating NGOs, teachers, adolescents</p> <p><b>PRE-RESEARCH:</b> Meeting held with partners to discuss survey process.</p> <p><b>RESEARCH:</b> Hired CBD staff to assist local research team in communities. PAVHNA and partners oversaw research process.</p> <p><b>POST-RESEARCH:</b> Presented survey findings through a national dissemination seminar attended by policymakers, media, NGOs, young people, teachers, parents.</p> <p>Youth involved as major stakeholders in all activities and in the national workshop alongside policy makers, planners and managers; this helped gain the support of youth for the initiative.</p>				
<b>Communication</b>	<p><b>POST-RESEARCH:</b></p> <ul style="list-style-type: none"> <li>Workshop held to discuss findings with various stakeholders.</li> <li>Report disseminated widely by PAVHNA.</li> <li>Media continues to assist by disseminating appropriate information on ARH.</li> </ul>				
<b>Macro Contextual factors</b>	<p>The study topic was a sensitive one and so policymakers did not want to be seen participating in any activity that may be construed as promoting adolescent sex outside marriage. Intense preparation and groundwork was undertaken, taking into account the sensitive nature of the survey.</p>			<ul style="list-style-type: none"> <li>ARH identified as priority area in development of National RH Programme; PAVHNA advisor on its Steering Committee</li> </ul>	

## Needs Assessment on Adolescent Reproductive Health in Pakistan

### Description of Research

High adolescent/youth pregnancy, low literacy rate/school enrolment and high school drop-out rates, large numbers of street children, low girl status and low esteem, child labour and high unemployment rate, and sexual abuse are some of the key characteristics of the life of many young people in Pakistan. Despite the fact that 23.4% of the population of Pakistan is aged 10-19 years and approximately 62.8 % are below the age of 25<sup>10</sup>, few policies or programmes recognise the need of this group for reproductive health information and services.

As a first step towards addressing this need, Pakistan Voluntary Health and Nutrition Association (PAVHNA) undertook a survey of relevant stakeholders in August 1999 and held a national workshop in May 2000 to disseminate and share the findings of the study and launch a dialogue among national policy makers and international NGOs on this topic.

The major findings of the survey indicated that young people felt the need to access information and counselling on adolescent reproductive health (ARH) at all stages of life from puberty onwards. Unfortunately, in the absence of any communication or information from parents or teachers or any other formal relationship, they turned to their peers, obtaining information that may be inaccurate or incomplete. A significant number of young people had experienced some sort of sexual abuse in their life.

### Research Process

#### *Pre-Research Stage*

PAVHNA is one of the first organisations to take the initiative and work proactively for adolescents' programmes in Pakistan. On the basis of the 1998 census data [which showed that 65% of Pakistan population was under 25 years of age], Begum Zeba Zubair, then President PAVHNA who passionately believed that adolescents were a completely ignored sector, worked hard to put together the first ever national seminar on the subject. However, she did not live to see the positive results of her initiative as she passed away two weeks before PAVHNA held the seminar "Adolescents–Key to the Future", which was held on November 17, 1999. The seminar became a regional event with participants from the SARC region; nearly all donor organisations in Islamabad sent a representative. It was largely attended by policy makers, programme managers, researchers, teachers, parents, youths themselves, national and international donors and regional participants from Bangladesh, Nepal and Sri Lanka. Recommendations indicated that stakeholders, especially the government, were ready to begin working with this group but did not know how to go about it.

Journalists and psychologists were also invited to the meeting as their contribution was potentially significant, the former to highlight youth issues in a positive manner to draw the attention of policy and programme towards it and the latter as they need to have more skills to work with adolescents. The seminar received good media coverage and was able to give visibility to adolescent reproductive health. The initiative was highly appreciated by a senior official from the Ministry of Population Welfare present at the meeting.

The event also helped PAVHNA in their future work, as it was able to focus on adolescents in all of their project sites and present it to the relevant stakeholders including policy makers wherever possible. With

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<sup>10</sup> Population Census Organization, 1998 Census of Pakistan

assistance from ICOMP (Malaysian Based NGO), a project proposal for the research study was submitted to UNFPA, New York entitled. “Adolescent Reproductive and Sexual Health: An Exploration of Trends in Pakistan”, which was approved and as a result, PAVHNA conducted the first-ever survey with adolescents between 15-21 years of age in four provincial cities of Pakistan. The research question was developed based on the realisation that there was a lack of information on young people’s reproductive health and the lack of provision of services for them in Pakistan. The study design was replicable in other settings within Pakistan and other Asian countries with characteristics similar to Pakistan.

The main aim of the study was to sensitise the policy makers and key stakeholders on ARH. The random survey covered both girls and boys, urban and rural areas, school going and out of school youth and working adolescents.

Stakeholders for the study were parents, participating NGOs, teachers and adolescents while the target audience for the study were adolescents, parents, NGOs working in the field of ARH, and the relevant Ministry. The NGO partners were selected on the basis of the rural-urban divide. The survey was conducted in Karachi, Quetta, Swabi and Gujranwala. PAVHNA had previous partners in the first three cities while in the case of the fourth, they contacted a known organisation to partner with them in this project.

#### ***Research Stage***

The research team was composed of PAVHNA and RAASTA Development Consultants. The interviewers were mostly field workers, supervisors from PAVHNA’s partner NGOs working in community based distribution (CBD) of reproductive health services and information. The NGOs and workers already had credibility in the community and in fact, this was the only reason that such a sensitive topic could be explored.

At first a consultation meeting was held to develop the research tools. RAASTA, in close coordination with PAVHNA trainers conducted the training for the interviewers, who were identified by the PAVHNA partners working in the community. The study was conducted through interviews, surveys of parents, gatekeepers and adolescents (310 youths and 110 gatekeepers) in the four cities. RAASTA carried out the data analysis.

#### ***Post-Research Stage***

A National Dissemination Workshop was held in May 2000 to disseminate results of the study, which was attended by approximately 100 participants: policy makers and planners from the national and provincial level including members from Ministries of Health, Population and Education, programme managers from PAVHNA and other NGOs, parents, teachers, youth/adolescent leaders from both the private and public sector, donors’ representatives from ICOMP, UNFPA Pakistan office, Futures Group International, World Population Foundation Islamabad office, and Population Council.

The findings of the study were presented in a report entitled “*Adolescents Reproductive and Sexual Health—an Exploration of Trends in Pakistan*”, a ground-breaking document, clearly indicating the urgent need to work directly with this age group. The results from the survey were the first step towards advocating the recognition of adolescents as a special entity and their needs, especially their reproductive health needs and rights. While the research team itself did not make any recommendations to either policymakers or the NGO community in their report, the participants of the workshops agreed that the key stakeholders needed to be sensitised, and educated on ARH issues. They recommended that there be continuous and sustained efforts on the part of PAVHNA to create and raise awareness among the key



stakeholders to build networks and alliances with national, regional and local level NGOs and civil society organisations (CSOs). One of the major tasks of this alliance would be to network with the government at district, provincial and national level.

### **Scale Up/Application**

In order to be able to scale up activities at a later stage, PAVHNA applied for funding during the study period itself to set up Youth Centres. This proposal was subsequently funded by Packard Foundation and has proved to be a very successful learning experience in the field of ARH in Pakistan.

### **Advocacy**

PAVHNA, its NGO partners as well as ICOMP used the study findings to advocate on adolescent issues. PAVHNA stressed the need to address ARH issues through programmes for the youth. The messages were directed at their partners and policymakers during seminars and also by using the help of the media to disseminate their messages. Awareness raising sessions were also held for community level gatekeepers. As a result of these efforts, greater support was received from community leaders and local government representatives.

### **Policy**

The Government included ARH as a priority area in the development of the National Reproductive Health Programme and invited PAVHNA to be an advisor in its Steering Committee. An ARH component has since been added to the national programme.

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### Young people's sexuality and sexual behaviour change in Mexico

Factors	Pre-research	Research	Post-research	Scale-up Activities	Application/Utilisation Evidence Base
<b>Research Process</b>	<ul style="list-style-type: none"> <li>• Research responding to knowledge gap</li> <li>• Topic finalised in consultation with research partners</li> <li>• Research partners: local health promoters and Mexfam coordinator.</li> <li>• Research considered highly relevant by stakeholders</li> <li>• Economic &amp; Social Research Council (ESRC), UK funded PhD</li> <li>• Ethical process documented</li> </ul>	<ul style="list-style-type: none"> <li>• Mexfam personnel involved in interviews</li> <li>• Qualitative study</li> </ul>	<ul style="list-style-type: none"> <li>• Preliminary results were discussed and opinions sought from young people, particularly the local GJ co-ordinator and fieldworkers on the project.</li> <li>• Clear interpretation of results and recommendations difficult because of range of complex issues</li> <li>• Additional funds for dissemination received from the ESRC. Wider audience targeted with this.</li> </ul>		<ul style="list-style-type: none"> <li>• Findings presented in publications and at conferences.</li> </ul>
<b>Stakeholder involvement</b>	<p><b>Stakeholders:</b> Mexfam, young people, Gente Joven (GJ) co-ordinator and field workers</p> <p><b>PRE-RESEARCH:</b> Mexfam not directly involved in study design but approved the project and facilitated implementation. Mexfam Director provided contacts for research to take place and occasionally assisted in arranging interviews.</p> <p><b>RESEARCH:</b> Young people, local GJ coordinator and fieldworkers consulted throughout.</p>				
<b>Communication</b>	<p><b>RESEARCH:</b> Researcher lived in the community where study conducted. Received progress updates from interviewers and Mexfam staff during course of informal conversations. Young people in the community were similarly kept informed informally of ongoing results during research process. The Director General of Mexfam was provided with general information about the research.</p> <p><b>POST-RESEARCH:</b></p> <ul style="list-style-type: none"> <li>• Dissemination strategies suggested and funded by Mexfam director and ESRC.</li> <li>• Wide range of dissemination strategies employed – report published in Mexfam bulletin, Mexfam website. Distributed in Mexico.</li> <li>• Workshop held for all programme coordinators nationwide</li> <li>• Findings presented at seminars attended by NGOs and government officials.</li> </ul>				
					<p><b>Policy</b></p> <ul style="list-style-type: none"> <li>• Director General of Reproductive Health, MoH incorporated results in their strategy</li> </ul> <p><b>Programmes</b></p> <ul style="list-style-type: none"> <li>• Director of National Program IMSS Oportunidades introduced changes in strategy - confirmed by Mexfam.</li> <li>• Whole GJ strategy was reviewed according to the research findings and much more importance is now given to the interaction between young people participating in the project.</li> <li>• Mexfam confirms that the research brought international recognition to the GJ programme. Related evaluation studies were instrumental in attracting attention of donors.</li> <li>• Former Mexfam Director General states that results of study used in several Mexfam funding applications, though not known whether the study directly helped in obtaining funding.</li> </ul>

**Macro  
Contextual  
factors**

- Sensitive topic in a Catholic country
- Due to severe financial crisis affecting implementation of reproductive health programmes, international support has sharply declined, curtailing further research in this area.

## Young people's sexuality and sexual behaviour change in Mexico

### Description of Research

The aim of this study, which was part of a PhD, was to identify the personal, social, and physical contexts in which sexual activity among young people takes place, the ways activity is explained and justified, and the processes of decision-making about sexual behaviour. It also examines the relationship between elements of sexuality revealed by the investigation, and the Gente Joven (GJ) programme, a peer-led, community outreach sexual health programme in Mexico. The research methods used were in-depth interviews, various key-informant interviews, participant observation of the GJ programme in the local community, and numerous informal group discussions. The principal findings of this research were that good communication is key to good sexual health, and a successful sexual health programme can change behaviour by encouraging good communication and critical thinking.

### Research Process

#### *Pre-Research Stage*

Following a literature review on theories of behaviour and behaviour change which identified a lack of knowledge around young people's sexuality and lack of in-depth study of sexual health programmes, the research was developed in the context of global concern about young people's sexual health needs.

The relevance of the research was confirmed by holding personal discussions with young health promoters and the Mexfam co-ordinator in Iztapalapa. As this was a dialogic process, learning was a two way process between the researcher and the community rather than just one-sided. Some of the questions were rephrased in consultation with the interviewers during the training process.

The research was initiated prior to the formation of ethics committees at the research institution at which the PhD was based. However, a rigorous ethical procedure was followed (this is outlined in the PhD thesis: see Publications list) and approval was obtained from Mexfam. The then Director General of Mexfam admits that in Mexico, ethical considerations tend to be implicit and are often set according to the researcher's criteria.

#### *Research Stage*

The research design was the most appropriate given the limited resources and time available. A quantitative component would have been ideal but that would have been beyond the scope of the doctoral study (to be completed by one researcher within three years) and very expensive.

The study was made possible by the interest of the Director General of Mexfam, the Mexican family planning association, which runs the GJ programme. Mexfam provided the contacts needed for the research to take place, and occasionally provided office space etc where necessary.

As interest in the study grew, more Mexfam personnel became involved in interviews, in facilitation of interviews, etc. The local Mexfam director provided support to the researcher. The research and research questions changed over time in response to the findings and to the research environment. The initial plan had been to conduct the investigation in a number of sites, with less depth in each site. High-quality interviewers, and good contacts in the area, however, meant that the research stayed focused on one area of Mexico City and a very detailed, in-depth study was possible.

### ***Post-Research Stage***

The interpretation of research was mainly done in London, but in consultation with the local stakeholders.

### **Communication**

According to the former Mexfam Director General, during the whole process, young people were informed about the on-going results of the study, though these were not necessarily the same people who provided input to the study because there was a high turnover of young people taking part in projects. Both the local director and director general of Mexfam were kept informed of the progress of the study and the general findings.

Once the data was analysed, a day-long workshop was held for Mexfam co-ordinators where the researcher presented and discussed the findings.

This was a small-scale research project with no built-in dissemination beyond the general write-up. There was initially no scope for dissemination to lay audiences, no extra time to produce materials, etc. It would have been easy for the results to have been buried in a library and never used. However, substantial interest in the results of this research by the ESRC and Mexfam has meant more dissemination activities have occurred than were originally thought possible. Further funding from ESRC allowed a period of one year of dissemination activities, including further analysis and writing of a publication, a one-month visit to Mexico where the activities described above took place. Without this extra year, it would have been extremely difficult to disseminate the results.

Formats of briefs, reports, etc. all were tailored for the relevant audiences. Although the project was to build theory about behaviour and behaviour change, dissemination of results was aimed at both lay and academic audiences. A wide range of dissemination strategies was employed (ongoing). Many dissemination strategies were suggested by the Mexfam Director General, who provided the means (budget, presentation facilities, etc.) for these strategies to be employed.

Reports were published in the Mexfam bulletin and on their website. The results were written up into a PhD thesis, copies of which have been distributed in Mexico and other countries. In addition, publication of articles in peer-reviewed scientific journals is in process (see publications list below). The findings were also presented at seminars, which were attended by NGOs and government officials. A film script based on the study was written by the researcher for advocacy purposes, but was never made into a film. The researcher left the script with Mexfam though the former Mexfam Director General is not aware of the existence of the script.

Findings were disseminated through the effort of the lead researcher, and through enthusiastic reception at Mexfam. The Director General of Mexfam, who considers the findings one of the most useful for the implementation of the GJ project, was very active in getting results disseminated through the organisation in a format that would be easy to understand and be applied in practice. In addition, he took responsibility for presenting the results within Mexfam.

## Scale Up/Application

### Policy

The Director General of Reproductive Health in the Ministry of Health has introduced changes in strategy as a result of the research findings as confirmed by the former Mexfam Director General.

### Programmes

As far as the former Mexfam Director General is aware, the program IMSS Oportunidades, the largest in Mexico of the kind, took into consideration the results and made changes to their programme strategies.

## PUBLICATIONS

1. Marston C (2001) "A man gets as far as a woman wants him to"? Sexual behaviour change among young people in Mexico. *PhD Thesis*.
2. Marston C (2004) *Gendered communication among young people in Mexico: implications for sexual health interventions*. *Social Science and Medicine* 59(3): 445-456
3. Marston C (2005) *What is heterosexual coercion? Interpreting narratives from young people in Mexico City*. *Sociology of Health and Illness* 27(1): 68-91
4. Marston C, Juarez F, Izazola J (2004) *Young unmarried men and sex: Do friends and partners shape risk behaviour?* *Culture, Health & Sexuality* 6(5): 411-424
5. Marston C (in press). "Using participatory approaches." In Aggleton P, Ingham R (Eds.) *Contexts and consequences: young people's sexual behaviour in the developing world*. London: Routledge
6. Marston C (in press) "Pitfalls in measurement of sexual coercion: what are we measuring and why?" In Jejeebhoy S *et al* (Eds) *Sexual Violence and Young People: Perspectives from the Developing World*. London: Zed Books
7. Marston C (2005). *Child sexual abuse in Mexico: a descriptive, qualitative study*. XXVth IUSSP International Population Conference, Tours, France 18-23 July
8. Marston C (2005). *Why do young people use or not use condoms at first sexual intercourse? A qualitative study in Mexico City*. XXVth IUSSP Population Conference, Tours, France 18-23 July
9. Marston C (2004) *Changing gender relations among young people: an ethnographic study of the Gente Joven ("young people") programme in Mexico City*. Presented at Global Forum for Health Research 8, Mexico City, November 16-20
10. Marston C, Juarez F, Izazola J (1999) *Young unmarried men and sex: Does commitment to a relationship affect reproductive health risk?* Presented at Population Association of America conference, New York, March 25-27
11. Marston C, Juarez F (in review) *Communication and condoms in Mexico: using ethnographic research to guide sexual health interventions*
12. Marston C, Juarez F (in review) *Barriers to use of condoms and hormonal contraceptives among unmarried young people in Mexico City*
13. Marston C, (2002) *Case study of the Gente Joven programme* in Mexfam Bulletin
14. Marston C (2004) *Sexual Intercourse: improving communication among young couples in Mexico* in ID21 Research Highlight at <http://www.id21.org/health/h5cm4g2.html>

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## Youth Sexual Health Radio Project in Mexico

Factors	Pre-programme	Programme	Post-Programme	Scale-up Activities	Application/Utilisation
<b>Research Process</b>	<ul style="list-style-type: none"> <li>• PATH funded pilot and development of manual</li> <li>• Meeting of potential partners</li> <li>• Needs assessment questionnaire administered in each state (1000 young people)</li> <li>• CORA training materials, IEC materials and other resources approved by UNFPA</li> <li>• Lotteries funded</li> </ul>	<ul style="list-style-type: none"> <li>• Lessons learned in the first state incorporated in activities in the second.</li> <li>• COESPOs (State Councils for Population) provided the administrative hub.                             <ul style="list-style-type: none"> <li>• Young people involved in design and evaluation of radio programmes</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Listener surveys in each state (500 young people)</li> <li>• Training manual updated</li> <li>• Results presented at CONAPO meeting</li> <li>• CONAPO organised workshop with all COESPOs at which Hidalgo COESPO presented the model and their experience with it</li> </ul>	<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: auto;"> <ul style="list-style-type: none"> <li>• Cascade effect of participants going back and training parents and young people within their institutions.</li> <li>• Radio programme together with a training manual will be available for use by teachers.</li> </ul> </div>	<b>Evidence Base</b>
<b>Stakeholder involvement</b>	<p><b>Stakeholders:</b> COESPOs, state education authorities, state health authorities, Mexfam, State Institute of Women, Tlaxcala State Institute of Youth, state universities, state radio broadcaster.</p> <p><b>PRE-PROGRAMME:</b> COESPOs convened meeting to identify partners. Once identified, meeting held to discuss model and identify roles and responsibilities. Approximately 1000 young people interviewed.</p> <p><b>PROGRAMME:</b> COESPO staff made broadcasts and put programmes together. Young people involved in design and evaluation of radio programmes.</p> <p><b>POST-PROGRAMME:</b> Listener survey conducted with 500 young people to ascertain views on the radio programmes. Findings from needs assessment, pre-programme, listener survey, post-programme, training and evaluation reports given to inter-institutional group in each state.</p>				<b>Policy</b>
<b>Macro Contextual factors</b>	<p>☞ The long-term viability of the programme in Tlaxcala State is now less certain due to the change of political party in power following elections in 2004 (this does not apply to Hidalgo).</p> <p>☞</p>				<b>Programmes</b>
					<b>Practice</b>

<ul style="list-style-type: none"> <li>• Funding proposals submitted for work in Guerrero State and elsewhere in Central America</li> <li>• UNICEF funding for roll out in Hidalgo State</li> </ul>
<b>Policy</b>
<ul style="list-style-type: none"> <li>• COESPOs to seek funding to undertake the training</li> </ul>
<b>Programmes</b>
<ul style="list-style-type: none"> <li>• <u>Hidalgo State</u> 21 professionals from 5 institutions trained. Cascade effect: 90 additional professionals, 1350 young people and 260 parents trained.</li> <li>• <u>Tlaxcala State</u> 54 professionals from 18 institutions trained Cascade effect: 75 professionals, 20 youth promoters, 4600 young people and 600 parents trained.</li> </ul>
<b>Practice</b>
<ul style="list-style-type: none"> <li>• Improvement in young people's knowledge and attitudes</li> </ul>

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## Youth Sexual Health Radio Project in Mexico

### Description of NGO programme

The aim of this programme in two states in Mexico, Hidalgo and Tlaxcala, was to end the climate of confusion around sexual and reproductive health (SRH) for young people. The programme aimed to create demand for sexual health services via a 36-week series of weekly radio programmes for young people, and improve the supply of services by training service providers to deal with adolescent sexuality issues effectively. The programme used a combination of mini radio dramas and talk shows developed by and for adolescents, which varied in content. There were eight major themes to the programme; each one, for instance 'teenage pregnancy' or 'sexual abuse' would be covered in at least three or four modules, in a carefully designed sequence. Young adult men and women moderated the discussions, and an expert in that particular field also sat in on the discussions. On-air questions were also taken from the listening audience via telephone calls and email. In addition to the radio programmes, the project included training of health care providers and youth service agency staff on how to deal with adolescent sexuality issues effectively. Having been trained, these staff then went back and trained colleagues, young people and parents. The programme commenced in Sept 2001 and concluded in October 2004.

### Programme Process

#### *Pre-Programme Stage*

CORA had previously carried out work on the education of young people on SRH issues involving theatre and television, and felt the way to reach greater numbers and those out of school was by using the radio. CORA undertook a pilot of the work in Puebla State with funding from PATH, using both radio and training service providers. After CORA participated in a workshop organised by Interact Worldwide (then Population Concern) for Latin American and Caribbean partners, many of whom were IPPF affiliates, the two organisations collaborated in developing a proposal to undertake the intervention in two other states in Mexico, which was successful in gaining UK lottery funding.

Implementation of the programme with the blessing of the National Council for Population (CONAPO) was in cooperation with the State Councils for Population (COESPOs). The COESPOs, which have a demographic focus, are also empowered to raise money for their own programmes and some are proactive in working in SRH and with young people. Working with COESPOs was essential in order to undertake the work in Mexico, but the partnership also gave [credibility](#) and authority to the programme and facilitated roll out to other states.

The COESPOs in the two selected states convened a meeting in their state with a range of organisations who would potentially be interested in the programme, and CORA made an introductory presentation at this. Those who wanted to be involved, thought they had something to offer and could commit resources to these, were then invited to further meetings with more detailed discussions of roles and responsibilities, resulting in letters of agreement. To that extent, they were self selected and had decided for themselves that the programme was relevant to them and so maintaining their levels of interest in the programme was not a problem.

The stakeholders/partners in this programme were the COESPOs, who were the conveners in their state for professionals in health, education, the more general social sectors, for youth and women, and for the training of professionals. Two COESPO members of staff in Hidalgo and one in Tlaxcala dedicated a large proportion of their time to this programme. These COESPO staff were members of the operative

group, that is, the group of young people who actually made the broadcast and put the programmes together. Other stakeholders included: state education authorities, state health authorities, Mexfam, State Institute of Women, Tlaxcala State Institute of Youth, the state universities, and state radio broadcaster.

The first meeting convened with the COESPOs that were identified in both states, agencies that were interested in being involved in the programme and those who were willing to commit resources. In the case of the state agencies who opted to get involved as well, each signed up to their commitment during a public meeting (following a series of introductory meetings where the model was presented and roles and responsibilities discussed) and, for the most part, fulfilled it. Agencies' senior staff formed an 'Inter-Institutional' group which acted in an advisory capacity, while responsibility for the day-to-day implementation of the project was undertaken by staff at other levels, with the COESPO taking the leading role, supported by regular visits from CORA staff and their associated consultants. There was thus strong ownership of the programme at the state level from an early stage.

In terms of engagement of the young people as stakeholders, aside from the operative group, who were working on the programme day to day, approximately 1,000 (approximately roughly half male and half female and approached at random in poorer areas, as indicated by COESPO) were interviewed at the outset of the project in each state to assess the general level of SRH knowledge, attitudes to SRH and gender issues and interest in such a programme, as well as the most convenient day and time for broadcasts.

#### ***Programme Stage***

Many of the trained professionals, especially those with SRH expertise, took part in the 'expert forums' section of the broadcasts, in which young people were able to put their questions to them. In addition there was a certain amount of linkage between the group of trained professionals and the operative group through the COESPO staff who were members of both. The professionals undertook four training modules of three days each and were given a number of handbooks to go with each. The handbooks covered topics such as adolescence and youth, including adolescent sexuality, and skill areas such as counselling.

#### ***Post Programme Stage***

The series of 36 programmes was followed up with a listener survey, in which 500 young listeners (approximately half and half male and female) gave details about their frequency of listening, their opinions on the content and format of each module, identified any benefits they considered they had gained from the programme and made any other general comments. Those listeners who wrote mini radio dramas that were chosen to be broadcast as part of the programme attended that broadcast and were interviewed about how they came to write it, their feelings, the theme, and the issues raised in the drama.

#### **Macro-Contextual Factors**

In order to ensure permission for the programme activities, it had to be implemented in cooperation with the COESPOs.

The programme needed someone to coordinate the work at state level with sufficient authority and influence to manage the meetings and to say that the programme was a good idea and seen to be a good thing to be involved with.

There was a question of whether the health system had the capacity to accommodate an increase in demand for SRH services.

The donor (Community Fund) gave advice to be more strategic in who was trained by the programme in order to achieve institutional change. For example, it was suggested that personnel from the training departments of each ministry be targeted. CORA did not feel they had the right to dictate to participating agencies who should be selected for training, although they accepted that SRH and young people tended to be viewed as women's work. In Hidalgo State, no men completed the training but CORA made more of an effort to influence selection of trainees in Tlaxcala and four men were included among those who successfully completed their training.

### Scale Up/Application

The findings from the needs assessment, pre-programme, and listener survey, post-programme, were given to the inter-institutional group in each state, as were training and programme evaluation reports. In Hidalgo, the COESPO decided to adopt the needs assessment questionnaire and apply it to each new year's intake at the secondary schooling level.

The idea that providers could pass on their skills was a good one and CORA are very good trainers. However, in retrospect it was unrealistic to expect the training participants to be confident enough to pass on their new skills to colleagues after their initial training. There was a need for greater support from CORA for trainees in terms of the multiplication of activities; it did happen to a limited extent in Hidalgo but was more successful in Tlaxcala, where an extension of the project period allowed for greater input from CORA dedicated to supporting this multiplication activity after the radio programmes were completed.

In future projects, it is intended to make and distribute cassettes or CDs of the broadcasts, together with teachers' manuals as a resource for teachers in community schools involved in SRH education. Interact Worldwide has obtained some funding from the World Bank which they can 'on-grant' to partners and a small proportion of this has been granted to CORA to develop the teachers' manuals.

### Programmes

21 professionals from 5 institutions were trained in Hidalgo State along with 54 professionals from 18 institutions in Tlaxcala. The discrepancy was because state elections were due to be held in Tlaxcala during which a change in government was expected, and it was feared that some of the people trained initially would be removed from their posts after the election. Therefore, the programme provided additional training to personnel at a lower level, as they were more likely to remain in post after the election.

### PUBLICATIONS

1. [Presentation file 'Dimensiones Sexuales' \(Sexual Dimensions\)](#)
2. ['Modelo de Mini Radionovelas Juveniles' \(Young People's Mini Radiodramas Model\)](#)
3. [Manuals for trained professionals – Series of 4 training modules: 'Promocionando la Salud de l@s Jóvenes' \(Promoting the health of young people\).](#)
4. [Manual for operative group members - 'Funciones y Habilidades del Grupo Operativo' \(Functions and Skills of the Operative Group\)](#)

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**Greater Involvement of PLHA in NGO Service Delivery: Findings from Burkina Faso, Ecuador, Zambia and India (Maharashtra)**

Factors	Pre-research	Research	Post-research	Scale-up Activities	Application/Utilisation
<p><b>Research Process</b></p>	<ul style="list-style-type: none"> <li>• Research question jointly identified by Alliance and Horizons. Validated by USAID (Washington, DC)</li> <li>• Question based on limited understanding of GIPA</li> <li>• Study designed by Alliance and Horizons research team in consultation with local study partners</li> <li>• Design reviewed by Horizons Ethics Board and those at local research institutes in each country</li> <li>• Funded by USAID through Horizons.</li> <li>• Some communications activities funded by Alliance's Communications Department budget; follow-on activities funded by individual field programmes.</li> </ul>	<ul style="list-style-type: none"> <li>• Study replicable in other countries with adaptations to suit local context</li> <li>• Local researchers employed as part of research team</li> <li>• Training provided for each local research team</li> <li>• Data analysis workshop held</li> </ul> <p><b>Key informants:</b> health workers; NGO staff; members and volunteers; former members of NGOs; beneficiaries of services provided by partner organisations; peer educators that were used by some of the NGOs to do workplace awareness raising, and people who attended these awareness raising sessions; relatives of PLHA who were involved in the participating NGOs; PLHA who were neither beneficiaries nor services providers; policymakers; community leaders.</p>	<ul style="list-style-type: none"> <li>• Stakeholder meetings held in each country</li> <li>• Findings presented in various formats and languages</li> <li>• Policy recommendations made regarding involvement of PLHA in organisations</li> <li>• Press coverage of meetings</li> </ul>	<ul style="list-style-type: none"> <li>• Set of tools and resources produced to enable organisations to assess themselves and determine type of GIPA involvement desired</li> </ul>	<p><b>Evidence Base</b></p> <ul style="list-style-type: none"> <li>• Findings presented at conferences.</li> <li>• National AIDS programmes are using the findings in their respective GFATM proposals.</li> </ul> <p><b>Advocacy</b></p> <ul style="list-style-type: none"> <li>• Endorsement by various national governments and organisations.</li> </ul> <p><b>Policy</b></p> <ul style="list-style-type: none"> <li>• Many study participants, including the Alliance have changed their organisational policies to ensure greater involvement of PLHA</li> </ul> <p><b>Programmes</b></p> <ul style="list-style-type: none"> <li>• NGOs and INGOs are making changes to their internal and programme policies based on the study recommendations.</li> </ul> <p><b>Practice</b></p> <ul style="list-style-type: none"> <li>• Organisations and individuals acknowledge better understanding of PLHA capabilities.</li> <li>• Some study participants have created positions for PLHA</li> </ul>

<p><b>Stakeholder involvement</b></p>	<p><b>Stakeholders:</b> Alliance, Horizons, local partners, service providers and users from participating NGOs, research teams in each country, MoHs, NGO partner networks, national AIDS councils, INGOs, CBOs.</p> <p><b>PRE-RESEARCH:</b> Local partners adapted master design to suit country context. Also designed questionnaires, focus group discussions, and decided how research to be carried out.</p> <p><b>RESEARCH:</b> Part of research team. Regular updates provided to keep them informed of research progress.</p> <p><b>POST-RESEARCH:</b> NGO partners involved in data analysis. Also allowed to revise the NGO profiles produced by the Alliance. Partners determined strategies for greater involvement of PLHA. All stakeholders invited to a workshop to present the final findings. Partners involved in presentation of findings.</p>
<p><b>Communication</b></p>	<p>Horizons, the Alliance and all country partners played a role in communication activities.</p> <p><b>RESEARCH:</b> Progress reports provided to stakeholders and participants to keep them informed of research progress.</p> <p><b>POST-RESEARCH:</b> Organisational profile produced for each participating NGO; contents of these fed into a national report for each country. Final report produced on overall study. Profiles and national reports produced in English, French or Spanish, depending on the country. Summaries and international reports produced in English. Also posted on Alliance website.</p>
<p><b>Macro Contextual factors</b></p>	<p>Stigma and discrimination against PLHA in all four countries. By targeting as wide an audience as possible, the Alliance and its partners tried to generate greater awareness of the positive contributions that PLHA make.</p>

## Greater Involvement of PLHA in NGO Service Delivery: Findings from Burkina Faso, Ecuador, Zambia and India (Maharashtra)

### Description of Research

Despite growing recognition of its importance, there has been little research that investigates PLHA involvement in the delivery of prevention, care and support services in developing countries and its effects on PLHA, others affected by HIV/AIDS and NGOs. To address this gap, the Population Council's Horizons Program and the International HIV/AIDS Alliance conducted a study of PLHA involvement in NGOs in four countries: Burkina Faso, Ecuador, Zambia, and India (Maharashtra). Seventeen NGOs participated in the study, all of who focus on HIV/AIDS prevention, care and support. A participatory approach was used throughout the study involving the NGOs. The study found that there are many ways for PLHA to take part in the activities of NGOs, and the four types of involvement – *access*, *inclusion*, *participation*, and *greater involvement* – embrace a wide range of roles. The most common types of involvement observed in the participating NGOs were *access* and *inclusion*. An important finding was that all types of involvement can make a difference and that meaningful PLHA involvement should not be equated with public visibility and disclosure. Policy recommendations were made regarding greater involvement of PLHA in organisations.

### Research Process

#### *Pre-Research Stage*

The study, which began in 1999, was initiated by the International HIV/AIDS Alliance through the Horizons<sup>11</sup> Program. While there was general awareness of Greater Involvement of PLHA (GIPA) principles at that time, it was unclear what they really meant. For the Alliance, which works with community-based organisations (CBOs) and NGOs, the issue of involvement of PLHA is one of their primary principles and so it was especially important to explore this to see how the principles can be and are applied in practice. While not explicit, there was an aim to have an impact at the policy level as well, whether at national levels or for global institutions. A literature review was also carried out to develop the research question. While the Alliance came up with the original idea for a research intervention on GIPA, Horizons provided the research 'reality check', helping to pull together a feasible design and approach. The proposal was developed by the Alliance in consultation with the Horizons Study Coordinator and submitted to the Horizons Review Board for approval.

At the conceptualisation stage (1998-99), part of the rationale was for the Alliance to work in countries where it had linking organisations. The initial contenders were Senegal, the Philippines, Ecuador and Burkina Faso. As the research topic was not a priority for the USAID Missions in Senegal and the Philippines, they were replaced with India (state of Maharashtra) and Zambia. Senegal was also replaced because there was already one Francophone country on the list while Zambia was selected because it had high prevalence of HIV.

The NGO partners in each of the study countries were:

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<sup>11</sup> The Horizons Program is implemented by the Population Council, International Centre for Research on Women (ICRW), Program for Appropriate Technology in Health (PATH), International HIV/AIDS Alliance, Tulane University, Family Health International, and Johns Hopkins University.

- Burkina Faso – Association African Solidarité (AAS); Association Laafi la Viim (ALAVI); Appui Moral Matériel et Intellectuel à l’Enfant (AMMIE); La Bergerie-Foi, Univers, Compassion; Association Responsabilité Espoir, Vie, Solidarité + (REVS+).
- Ecuador – Fundación Dios, Vida y Esperanza; Fundación Esperanza; Fundación Siempre Vida; Fundación Vivir.
- India (Maharashtra) – Project Child of Committed Community Development Trust (CCDT), Maharashtra Network for Positive People (MNP+), Salvation Army Mumbai HIV/AIDS Community Development Program, Society of Friends of the Sassoon Hospital (SOFOSH)
- Zambia – Copperbelt Health Education Project (CHEP); Hope Humana People to People, Kara Counselling and Training Trust, Salvation Army Chikankata Mission Hospital

The main implementing partners were:

- Burkina Faso – Initiative Privée et Communautaire de lutte contre le VIH/SIDA (IPC); Population Council office
- Ecuador – Kimirina; Centro de Estudios de Población y Desarrollo, Social (CEPAR).
- India – Tata Institute of Social Sciences (TISS); Regional Horizons/Population Council Office in Delhi
- Zambia – Population Council Office, Zambia Integrated Health Program (ZIHP); Alliance Zambia

Other partners were:

- Burkina Faso – American Embassy; UNAIDS
- India – Indian Network for Positive People (INP+); USAID Mission
- Zambia – Network of Zambian People Living with HIV/AIDS (NZP+); USAID Mission

The research idea was presented to the NGO partners after which, other partners were invited to join. It was emphasised that the findings would have practical implications for them. Following this a local research team was selected in each country, which comprised of a national coordinator and 2-3 research assistants, who were selected on the basis of two criteria: field experience and ability to work with the community, particularly PLHA. According to the Principle Investigator (PI), some researchers had little academic background but were chosen because they were closer to the community than others. The researchers were independent rather than part of any of the partner organisations. Transcribers also came in at various points of the research.

This was followed by a five-day orientation workshop for the partners and the local research teams. The methodologies for the study were presented to the partners and local researchers, and discussions held to discuss the design, tools, and determine the key informants. In some countries, this workshop acted as the final selection stage for the local research team based on observations of their ability to interact with PLHA on a daily basis. Candidates who had discriminatory attitudes towards PLHA (either verbally or through body language) were not selected. Towards the end of the workshop, all the stakeholders were invited and the study was presented to them. Some partners were involved in presenting the research ideas to the stakeholders.

At the orientation workshop, two people from each partner NGO were chosen as the key contacts. It was their role to disseminate information on the study within their organisations and amongst their members to get support for the study.

### ***Research Stage***

Some of the documents such as the questionnaires, informed consent forms, and photo voice descriptions were translated into the local languages. Throughout the study it was ensured that everything was



documented. Since the study did not take place simultaneously in all four countries, lessons learned in one helped inform the design and implementation in a subsequent country study.

On conclusion of the fieldwork in each country, a data analysis workshop was held to which the partner organisations were invited to participate in the data analysis. The findings were shared with them and it was their role to share this beyond with other people who were involved in the study. An organisational profile was produced for each participating NGO and drafts of these were given to the respective organisations before the data analysis workshop, which they were able to revise as they thought appropriate. Strategies for encouraging involvement of PLHA were thought of by the partner NGOs themselves.

The study ended later than originally planned (expected 2000; final report ready in early 2002) as a result of underestimating how long it would take to carry out a four-country study, supervising four teams, setting up and carrying out the study in each country eg. logistics issues, finding time to hold focus group discussions with organisations that are busy, translation of documents into local languages. Bureaucracy in terms of setting up Memoranda of Understanding between the country partners and research institutes and research teams also caused some delays. Contingency funding existed in the application, which had to be topped up subsequently due to the extension of the research period.

While there was great interest in the study, it was seen as an additional activity by the partner organisations and respondents and so at times they found it difficult to contribute to the study. This added to the delays in completion of the study.

#### ***Post-Research Stage***

Stakeholder meetings were held in each country to which all those who were at the original stakeholder meeting were invited. The findings were presented by the NGO partner organisations, people from the partner networks and the local researchers.

A set of tools and resources was produced based on the study findings to assess where an organisation is in relation to GIPA, to assess what the existing level of involvement of PLHA is, what the barriers to involvement are, and to assess their strengths and weaknesses. The typology helps organisations decide on what kind of involvement to plan for.

#### **Communications**

Horizon's role involved producing the summaries, distributing them to those on their dissemination lists, posting the summaries on their website, and coordinating with the Alliance to determine who would disseminate what to whom to avoid overlap.

Strategies were developed for the different products throughout the study with a final strategy for the international report and summary at the end. The strategy for the first Horizon's published Study Summary (pilot phase in Burkina Faso) was to disseminate it to their constituents and have the Alliance disseminate copies to its primary stakeholders including country offices, linking organisations and other study participants. This was also the strategy for the final four-country study summary. There were sub-strategies for each country audience as well such as the research institutes, NGOs, donors, UNAIDS representatives in the study and neighbouring countries, etc.

Due to the size of some reports, the fact their target audience was relatively small and the prohibitive cost of printing (and posting) large quantities of them, it was considered more appropriate to disseminate

limited quantities of hard copies to the stakeholders, rather than to a wider audience. In general, at the time of the PLHA study, the Alliance was not producing and disseminating publications in large numbers.

However, to ensure that the reports could be accessed electronically, PLHA study documents have been made available to download from the Alliance website since 2001. Some reports are also available to order in printed format through the Alliance website.

The findings from Burkina Faso and Ecuador were presented at the Durban International HIV/AIDS conference (2000); Melbourne Asia-Pacific AIDS conference (2001); final findings were presented at the Barcelona International AIDS conference. The Principle Investigator/International Study Coordinator attended the PLHA conference in Warsaw (1999). The findings have also been presented to the WHO and UNAIDS. All reports are posted on the Alliance website. Findings are also presented at community fora.

### **Scale-Up/Application**

While it is difficult to attribute any outcomes directly to the study, various developments have occurred on the PLHA involvement front in the four countries since the results were published.

Ecuador – One of the study participants left the organisation he was with to start a more active PLHA movement in Ecuador. At the peak of their activities, they formed a coalition and approached the American Court of Human Rights to submit 150 precautionary measures on behalf of positive people. In another case, one of the MoH personnel who attended the final stakeholder meeting subsequently went on to head the National AIDS Programme and quoted and used the study findings in Ecuador's proposal to the GFATM, which was successful.

Zambia – Findings were used to develop the new national HIV/AIDS policy, involving positive people and involving communities in different aspects of HIV programming.

India – National AIDS Control Organisation (NACO) called upon Alliance India to be part of consultations on involvement of PLHA. They were asked to feed into the recent NACO policy and to comment on them. In 2004, the PI also designed a training course for NGOs based on the study's findings. It was successfully tested with several NGOs and CBOs from Kerala and Tamil Nadu.

Burkina Faso – Horizons carried out an assessment on the impact of the PLHA involvement study in Burkina Faso, which found that it has had a direct impact on NGOs and national policies, as informed by the PI. There is evidence that groups that participated in this study benefited enormously from it in terms of organisational strengthening as a result of taking on board some of the study recommendations. "Association African Solidarité" has grown from a small relatively unknown community group, started by a couple of PLHA to a high profile NGO that provides services to PLHA. It is also currently implementing a unique pilot project for access to treatment with the Alliance's support. The PLHA study also helped catalyse the formation of PLHA groups in Burkina Faso.

Within the Alliance itself, both at the Secretariat and in its country offices, policies are being examined in order to incorporate the study findings and to reflect the involvement of PLHA, for instance in its medical benefits policies and HIV in the workplace policy. These have been shared widely with large international NGOs that have in turn developed their own policies based on that of the Alliance. Since the study the Alliance has also been part of the UK NGO AIDS Consortium Working Group on HIV in the Workplace. The Alliance prepared a policy statement paper on PLHA involvement for UNGASS in 2001.

Since the study, various governments and international bodies have incorporated GIPA principles in national HIV policies, though it is difficult to attribute this to the Alliance study.

Findings from this study have fed into a research proposal for the ARV Community Education and Referral Project (a Horizons research project; implementation by Alliance).

Behaviour or attitudinal changes – All study partners felt the study was very useful and that it highlighted various issues. While not formally documented, the Alliance project staff confirmed that various charity organisations and partner organisations felt that by the end it helped dispel misconceptions about the capabilities of PLHA. Organisations attending the stakeholder meeting that had not worked with positive people before and met positive people networks at the meeting were influenced by them and learned from them.

In all four countries, stigma was cited as the primary reason for limited involvement of PLHA in NGOs. For some organisations this is still a limiting factor for application of the recommendations from the study. In Ecuador, money is also an issue ie. those who are poor do not have time to be involved in NGO activities. HIV is also seen as a male issue or that of homosexuals and commercial sex workers.

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2. *Greater involvement of PLHA in NGO service delivery: Findings from a four-country study*, Horizons Research Summary (June 2002)
3. *The Involvement of People Living with HIV/AIDS in Community-based Prevention, Care and Support Programs in Developing Countries. A Multi-country Diagnostic Study*. International HIV/AIDS Alliance (July 2003)
4. *The Involvement of PLHA in the Maharashtra Network for Positive People (MNP+), Maharashtra, India: Diagnostic study on the involvement of PLHA in the delivery of community-based prevention, care and support services*. International HIV/AIDS Alliance and Horizons (2001)
5. *The involvement of PLHA in the Project Child of Committed Communities Development Trust (CCDT), Maharashtra, India – Diagnostic study on the involvement of PLHA in the delivery of community-based prevention, care and support services*. International HIV/AIDS Alliance and Horizons (2001)
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10. *La Participation des Personnes Vivant avec le VIH/SIDA dans les Associations de Lutte contre le SIDA au Burkina Faso : Synthèse des résultats de la recherche*. International HIV/AIDS Alliance and Horizons (1999)

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15. *Resumen del Estudio – La participación de las Personas Viviendo con VIH/SIDA en las actividades comunitarias de prevención, atención y apoyo en Ecuador.* International HIV/AIDS Alliance and Horizons (2000)
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18. *Perfil Fundación Esperanza, Ecuador – Estudio sobre la participación de las personas viviendo con VIH/SIDA en las actividades comunitarias de prevención, atención y apoyo.* International HIV/AIDS Alliance and Horizons (1999)
19. *Perfil Fundación Siempre Vida, Ecuador – Estudio sobre la participación de las personas viviendo con VIH/SIDA en las actividades comunitarias de prevención, atención y apoyo.* International HIV/AIDS Alliance and Horizons (1999)
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27. *Profil Association La Bergerie – Foi, Univers, Compassion, Burkina Faso – Etude sur la participation des Personnes Vivant avec le VIH/SIDA dans les activités communautaires de prévention et de prise en charge.* International HIV/AIDS Alliance and Horizons (1999)

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1	Testing a Model to Improve Postabortion Care in Burkina Faso and Senegal	Placide Tapsoba Program Associate	Population Council, Ghana	ptapsoba@pcaccra.org
2	Pharmacists' role in managing sexually transmitted infections: policy issues and options for Ghana	Susannah Mayhew Lecturer, Health Policy and Reproductive Health	Centre for Population Studies, LSHTM, UK	<a href="mailto:Susannah.Mayhew@lshtm.ac.uk">Susannah.Mayhew@lshtm.ac.uk</a> Tel: + 44 (0) 207 299 4672
3	Strategies for managing the dual risks of unwanted pregnancy and sexually transmitted infections among adolescents in rural Kenya	Charles Nzioka	University of Nairobi/ International Institute for Educational Planning, France	<a href="mailto:c.nzioka@iiep.unesco.org">c.nzioka@iiep.unesco.org</a> (Tel: + 33 (0) 1 45 03 78 14); <a href="mailto:czioka@uonbi.ac.ke">czioka@uonbi.ac.ke</a>
4	Creating linkages between treatment for incomplete abortion treatment and family planning - What works best in Kenya?	Monica Wanjiru Regional Communications Officer	Population Council, Kenya	mwanjiru@pcnairobi.org
5	Improving the management of STIs among MCH/FP clients at the Nakuru Municipal Council Clinics	Monica Wanjiru Regional Communications Officer	Population Council, Kenya	mwanjiru@pcnairobi.org
6	Enhancing the continuum of Care of HIV/AIDS infected and affected Patients in resource constrained settings in KwaZulu-Natal, South Africa: Getting Research into Policy and Practice	Robert Pawinski Director, Enhancing Care Initiative	Nelson R Mandela School of Medicine, University of KwaZulu Natal, South Africa	<a href="mailto:pawinskir@ukzn.ac.za">pawinskir@ukzn.ac.za</a>
7	Impact of maternal syphilis on pregnancy outcome in Tanzania	David Mabey Professor of Communicable Diseases	Dept. of Infectious and Tropical Diseases, LSHTM, UK	David.Mabey@lshtm.ac.uk Tel: +44 20 7927 2297
8	Social marketing of pre-packaged treatment for men with urethral discharge (Clear Seven) in Uganda	Jimmy Whitworth Head of International Science	Wellcome Trust, UK	j.whitworth@wellcome.ac.uk
9	Nevirapine for Prevention of Mother-to-Child Transmission of HIV-1 in Uganda	Michele Lanham Dissemination Coordinator	Family Health International	<a href="mailto:MLanham@fhi.org">MLanham@fhi.org</a> Tel: 919-544-7040 x 504
10	Community-based distribution in Zimbabwe	Monica Wanjiru Regional Communications Officer	Population Council, Kenya	mwanjiru@pcnairobi.org

11	Introducing Emergency Contraception in Bangladesh	Sharif Mohammed Ismail Hossain Project Director, FRONTIERS	Population Council, Bangladesh	<a href="mailto:drsharif@pcdhaka.org">drsharif@pcdhaka.org</a> Tel: +880 288 21227/ +880 882 6657
12	Sex work and migration in Cambodia: the dangers of oversimplification	Joanna Busza Lecturer	Centre for Population Studies, LSHTM, UK	<a href="mailto:Joanna.Busza@lshtm.ac.uk">Joanna.Busza@lshtm.ac.uk</a> Tel: +(0) 20 7299 4619
13	Increasing the uptake of IUCD in Nepal	Sally Kidsley Lecturer	Opportunities and Choices, University of Southampton, UK	S.G.Kidsley@soton.ac.uk
14	Randomised control trial of participatory intervention with women's groups in birth outcomes in Nepal	Anthony Costello Head, International Perinatal Care Unit	Institute of Child Health, UK	A.Costello@ich.ucl.ac.uk
15	Needs Assessment on Adolescent Reproductive Health in Pakistan	Yasmeen Qazi/Rehana Rashdi Former Director/Current Director	Independent Consultant/ PAVHNA, Pakistan	qaziyas@hotmail.com pavhna@super.net.pk
16	Young people's sexuality and sexual behaviour change in Mexico	Cicely Marston Lecturer, Div of Epidemiology	Division of Epidemiology, Imperial College, UK	<a href="mailto:c.marston@imperial.ac.uk">c.marston@imperial.ac.uk</a>
17	Youth sexual health radio project	Judy Skelton Senior Programme Officer	Interact Worldwide, UK	SkeltonJ@interactworldwide.org Tel: +44 (0)20 7241 8512
18	Greater involvement of PLHA in NGO service delivery: findings from a four-country study	Pam Decho Project Support Officer, Care & Impact Mitigation Team	International HIV/AIDS Alliance, UK	<a href="mailto:PDecho@aidsalliance.org">PDecho@aidsalliance.org</a> Tel: +44 (0) 1273 718 957