

Improving lives, knowledge, and understanding

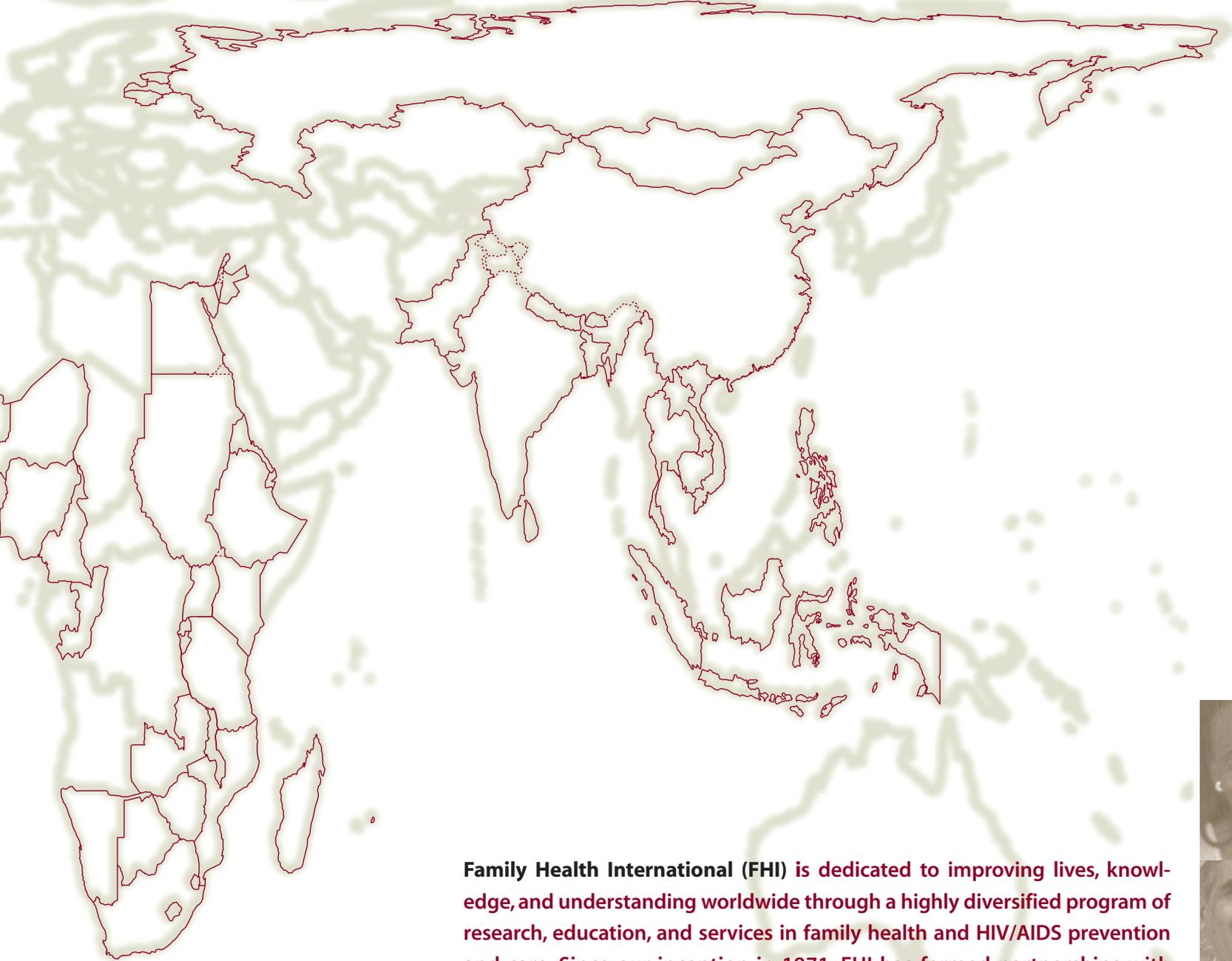




COUNTRIES IN WHICH FHI IS ACTIVE:

BAHAMAS	MALAWI*
BANGLADESH*	MALI
BENIN	MAURITANIA
BRAZIL	MEXICO*
BOTSWANA	MOZAMBIQUE
BURUNDI	NAMIBIA*
BURKINA FASO	NEPAL*
CAMBODIA*	NICARAGUA
CAMEROON	NIGER
CANADA	NIGERIA*
CHILE	PAKISTAN
CHINA	PANAMA
CONGO*	PERU
COTE D'IVOIRE*	PHILIPPINES*
DOMINICAN REPUBLIC*	RUSSIA
EAST TIMOR*	RWANDA*
EGYPT*	ST. KITTS*
EL SALVADOR	ST. LUCIA
ERITREA*	ST. VINCENT
ESTONIA	SENEGAL*
ETHIOPIA*	SOUTH AFRICA*
GHANA*	SUDAN
GUATEMALA	SRI LANKA
GUINEA	SURINAME
GUYANA	SWAZILAND
HAITI*	TANZANIA
HONDURAS	THAILAND*
INDIA*	TOGO
INDONESIA*	TRINIDAD & TOBAGO
JAMAICA	UNITED KINGDOM*
JORDAN*	USA*
KENYA*	UGANDA
LATVIA	VENEZUELA
LAOS	VIETNAM*
LESOTHO	ZAMBIA*
LITHUANIA*	ZIMBABWE*
MADAGASCAR*	

* LOCATION OF FHI OFFICES



Family Health International (FHI) is dedicated to improving lives, knowledge, and understanding worldwide through a highly diversified program of research, education, and services in family health and HIV/AIDS prevention and care. Since our inception in 1971, FHI has formed partnerships with national governments and local communities in dozens of countries throughout the developing world to support lasting improvements in the health of individuals and the effectiveness of entire health care systems.



LETTER FROM THE CEO OF FHI

FHI's mission—to improve lives worldwide through research, education, and services in family health—has never been more compelling. The numbers alone spell out the challenge in both reproductive health and HIV/AIDS: a world of more than six billion people with millions living in abject poverty made worse by unwanted pregnancies, unsafe abortions, maternal death and disabilities, and sexually transmitted infections, including HIV/AIDS. In just two decades, HIV/AIDS has claimed an estimated 25 million lives, with as many as 13 million children under the age of 15 having lost one or both parents. People of the developing world, especially women, the young, and the poor, bear most of the burden—a stark reminder of the inequities of today's world.

Family Health International is providing comprehensive responses to these challenges in partnership with multiple organizations throughout the world and with funding from the U.S. Agency for International Development, the U.S. National Institutes of Health, foundations and other development agencies. We are working locally to meet the needs of individuals and communities through programs in Africa, Latin America, Asia, and Eastern Europe that address short-term requirements while building long-term sustainability. We are working globally to establish a solid scientific foundation for public health interventions, to improve knowledge and understanding, and to adapt lessons learned in one setting to other settings.

During the past three years, FHI has grown at a compounded annual rate of more than 20 percent and is achieving total revenues in excess of \$108 million in FY 2002. To manage this progressive growth, FHI established two new operating institutes in 2002: the Institute for Family Health and the Institute for HIV/AIDS. These two institutes bring focus to our leading expertise and programs in family and reproductive health as well as in HIV/AIDS prevention, care, and treatment, and assure a solid infrastructure going forward. Mechanisms are in place to maximize synergies between the two operating institutes as required to meet some of the world's most challenging public health demands.

As we look to the future, FHI's expert staff of more than 700 is committed to achieving excellence in each program of work, expanding our understanding of the evolving health needs of women and their families in developing countries, and assuring that we are equipped and positioned to address those requirements with competence, vigor, and determination.



Albert J. Siemens, PhD
Chief Executive Officer



A World in Need ... A Continent in Crisis

By the end of 2001 an estimated 40 million people were living with HIV/AIDS throughout the world. Another 25 million already had died from HIV-related causes since the AIDS epidemic was first reported in 1981. In 2001 alone, five million people became infected with the AIDS virus—two million of them women—and more than a million previously infected women died from AIDS.

Worldwide, HIV/AIDS is the fourth leading cause of death. But in sub-Saharan Africa, it is the leading cause. Seven of every 10 people in the world who are living with HIV/AIDS, or are newly infected with the virus, live in this region.

Young people, particularly young women, are disproportionately affected by HIV/AIDS. One of every three people living with HIV/AIDS worldwide is 15 to 24 years of age. About two-thirds of the estimated 8.6 million HIV-positive young people in sub-Saharan Africa are young women.

Women face other reproductive health challenges besides HIV/AIDS. More than 500,000 women each year die during pregnancy or childbirth, 99 percent of them in developing countries. For every woman in the developing world who dies from pregnancy-related complications, 30 to 100 others survive—but with serious disease, disability, or physical injury related to the pregnancy.

Women also acquire other sexually transmitted infections (STIs) in greater numbers than men. They are at greater risk for asymptomatic, or “silent,” infection that may go untreated for years. They generally suffer more severe after-effects of STIs, including infertility. And having other STIs also increases the risk of infection with HIV.

Only 40 percent of women in developing countries (except China) use a modern method of contraception, and an estimated 120 million women worldwide have some type of unmet need for family planning services. The result is tens of millions of unwanted pregnancies, many leading to unsafe abortion, and shocking numbers of women suffering unnecessary death or disability. As populations increase, there will have to be a significant increase in family planning services simply to maintain, much less improve, that 40 percent level.



A BLEAK FUTURE FOR COMING GENERATIONS?

Despite the enormous number of people who are infected with HIV, theirs is only part of the story of AIDS. Many leave young children who must be raised by relatives or are left to fend for themselves. A report issued jointly by the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Children's Fund (UNICEF), and the U.S. Agency for International Development (USAID) at the 14th International AIDS Conference in Barcelona in July 2002 said AIDS will leave 20 million children in Africa without one or both parents by 2010. That is nearly double the current number, 11 million.

Today, 44 percent of the population in sub-Saharan Africa is under age 15—three times the percentage in developing countries elsewhere. How will these young people cope as they come of age sexually amidst AIDS, the deadliest epidemic the world has ever known? Will they have the knowledge to protect themselves against HIV infection? Who will teach them? As the epidemic progresses and more infected adults die, who will be left to care for their children and aging parents?

CREATING CHANGE THROUGH PARTNERSHIPS

Family Health International is dedicated to improving the lives of men, women, and children worldwide through a diverse program of research, education, and services in HIV/AIDS prevention and care, and family and reproductive health. Since our founding in 1971 as a nonprofit research and technical assistance organization, FHI has conducted or participated in thousands of studies and programs to combat HIV/AIDS and other STIs, improve maternal and neonatal health, increase contraceptive choice, and mobilize young people in protecting their own sexual and reproductive health.

FHI has offices in more than 30 countries throughout the developing world. FHI's own family includes more than 700 dedicated professionals and support staff who represent such varied disciplines as anthropology, biostatistics, business, demography, economics, education, epidemiology, journalism, medicine, pharmacology, psychology, public health, and sociology.

While FHI's talents are deep and diverse, three decades in public health have taught us that partnerships are the key to successful, sustainable programs. Our partners include:

- Program beneficiaries, such as the young people we involve in designing and implementing programs to serve their peers

- Central and local governments whose commitment and cooperation are essential to any public health program's success
- Local and international organizations and assistance agencies with which we pool our skills and resources to achieve common goals
- Schools, universities, hospitals, and clinics where research is conducted, services are delivered, and new health professionals are trained
- Donors and foundations whose financial support makes the work possible.

We are sought as a partner because of our expertise in:

- Applied research
- Behavior change communication
- Education and training
- Building local research and service capacity
- Drug and device development
- HIV/AIDS prevention, care, support, and treatment
- Reduction of maternal death and disability
- Special programs for at-risk youth
- Scientific publishing and other strategic information dissemination.

Sometimes our role is to lead. Other times it may be to counsel, train, or provide technical assistance. However we participate, FHI is always a highly valued team member working together with many others around the globe to meet both current and future health challenges.

ABOUT THIS REPORT

The sections that follow illustrate some of the ways FHI is helping to address the world's most pressing health issues as we:

- Target a wide range of public health needs in Kenya through a comprehensive, integrated program of services and research
- Focus the energy and expertise of young people on what they need to protect themselves and stay healthy
- Broaden access to safe, affordable, and effective reproductive health services and products
- Evaluate the most effective methods to protect against STIs, including HIV
- Improve the care, support, and treatment of people living with HIV/AIDS
- Expand voluntary HIV counseling and testing.

To learn more about us, please visit FHI on the Web at <http://www.fhi.org>.







Responding to Kenya's Multiple Challenges

By any measure Kenya faces extraordinary public health challenges. The nation is grappling with how best to address its growing HIV/AIDS epidemic, an expanding population of young people, and already overburdened family planning and reproductive health services. The statistics paint a powerful picture:

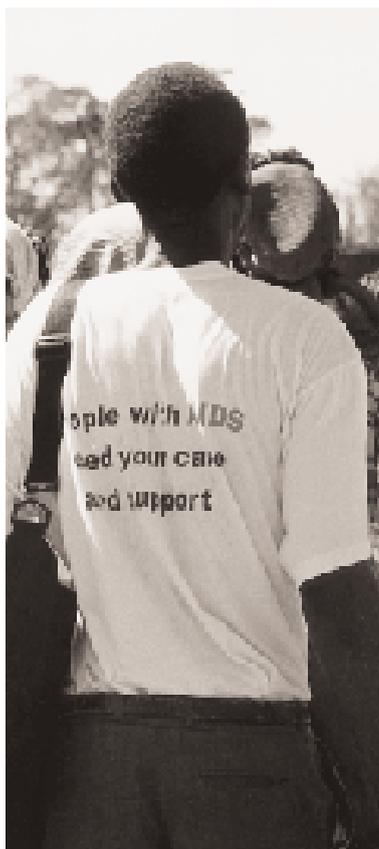
- Life expectancy dropped in 2001 to 49 years of age, from a high of 57 years in 1990
- Forty-four percent of Kenya's 30 million citizens—13.2 million people—are under 15 years of age
- Fifteen percent of 15- to 24-year-old females—and nine percent of males the same age—are HIV-positive
- Half of all HIV-infected Kenyans are women; a large proportion are between 15 and 19 years old
- Almost one-quarter of married women need, and have no access to, family planning.

HELPING THE NATION COPE—COMPREHENSIVELY

Building on a country's or community's existing capacity is one of FHI's central strategies. This is how we ensure that our support and technical assistance will yield sustainable programs that have a lasting impact. Because Kenya is burdened on multiple fronts, FHI is helping to build and sustain a comprehensive response by:

- Providing technical assistance in HIV prevention and care to communities in four regions with high HIV prevalence
- Expanding access to voluntary counseling and testing (VCT) for HIV through the 47 new community sites we helped develop
- Providing support in identifying and treating people with tuberculosis and other opportunistic infections that threaten the lives of people with HIV/AIDS
- Supporting and caring for people infected and affected by HIV/AIDS
- Ensuring a safe blood supply through a new centralized service of regional collection centers promoting voluntary blood donation.





- Providing technical assistance in contraceptive technology and family planning research, including the integration of family planning with STI prevention and HIV/AIDS services.

The goal of FHI's research in Kenya is to provide a basis for developing programs and policy. We are currently working with the Kenya Ministry of Health, the National Network of AIDS Researchers in East and Southern Africa, the University of Nairobi, and the University of Ghent to:

- Test approaches to providing antiretroviral (ARV) drug therapy to pregnant HIV-positive women to reduce mother-to-child HIV transmission
- Test messages that promote condom use, including dual protection against unwanted pregnancy and HIV transmission
- Test the viability of integrating family planning with VCT services
- Test strategies to overcome medical barriers to family planning services
- Assess Kenyans' ability and willingness to pay for family planning services.

“Rehabilitating” the intrauterine device

One way we are applying research findings is in our support of USAID/Kenya, the Kenya Ministry of Health (MOH), and other organizations in improving the position of the intrauterine device (IUD) in the country's family planning program. New data confirm the safety of the IUD, including recent findings that suggest that IUDs are not associated with increased risks of pelvic inflammatory disease, even among HIV-infected women, or with increased viral shed-

ding among HIV-infected users. These findings further support the view that the IUD is among the safest, most effective, and economical forms of reversible contraception for HIV-infected and HIV-uninfected women alike.

Despite this evidence, IUD use in Kenya has declined by more than 70 percent over the last 14 years, a trend the MOH would like to reverse. FHI is working with the Ministry, Engender Health, PRIME (under the AMKENI Project),

Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), and other organizations to “rehabilitate” the IUD, with the aim of assuring that the device is offered as an alternative for eligible clients. The effort involves targeting research results to policy-makers and key stakeholders, reviewing current service provision standards and guidelines, and phasing training and support activities in targeted service delivery points around the country.

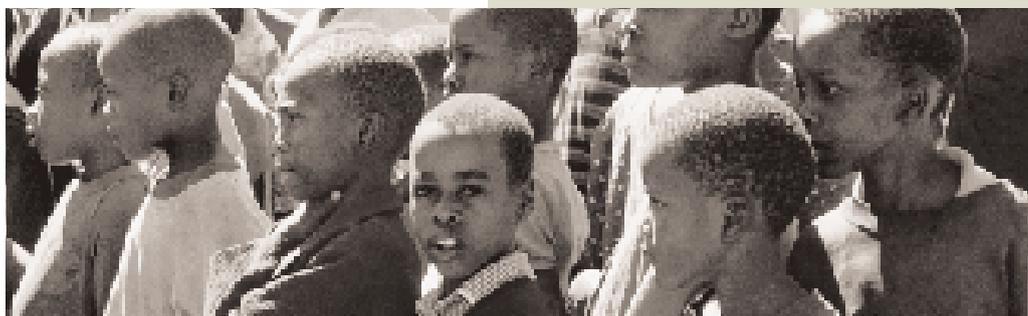


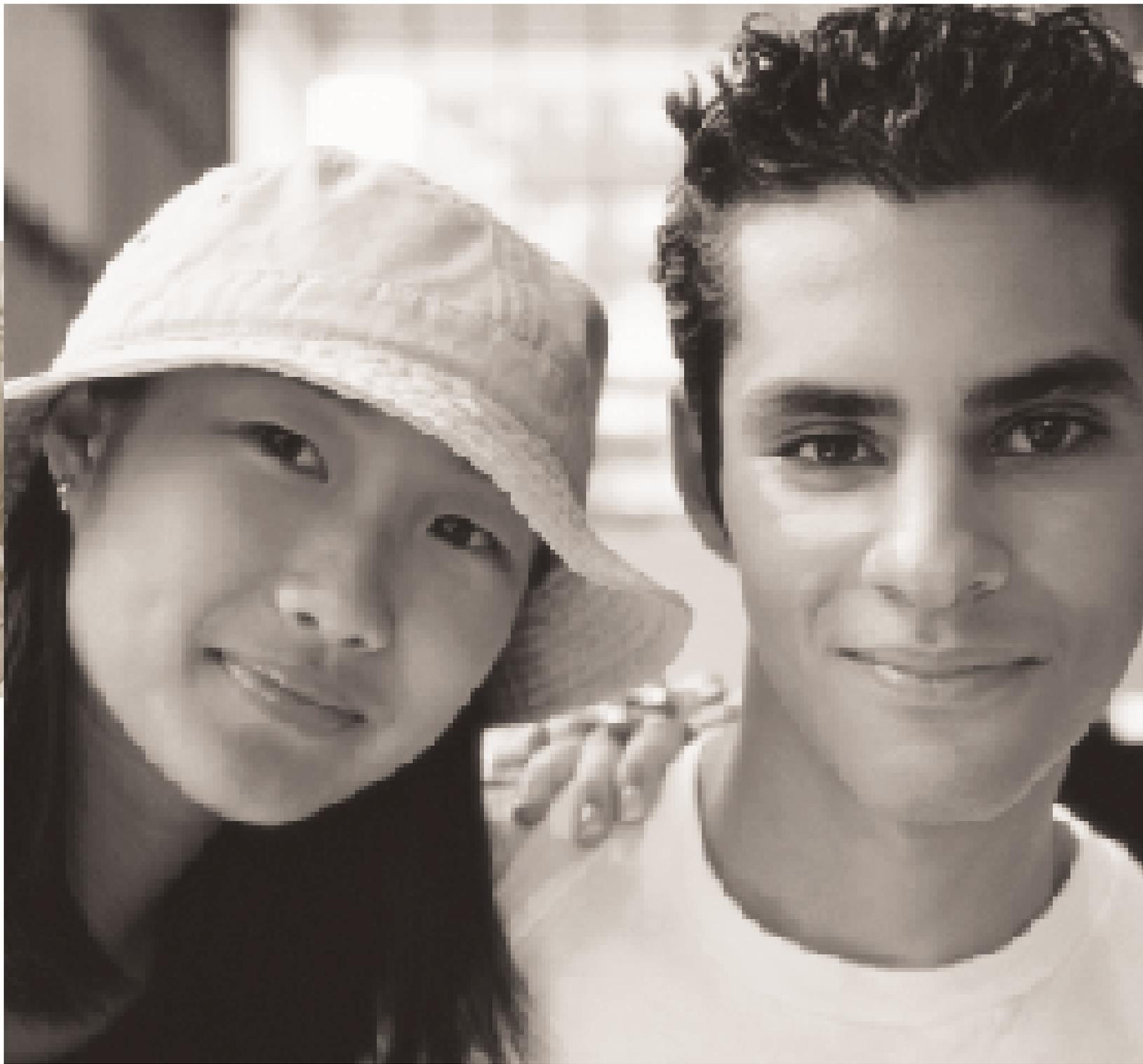
"I like the professional work environment at FHI, which has allowed me to be creative and innovative. As a Kenyan, I am fulfilled when the work I do at FHI improves reproductive health policies or service delivery here in Kenya or in the region."

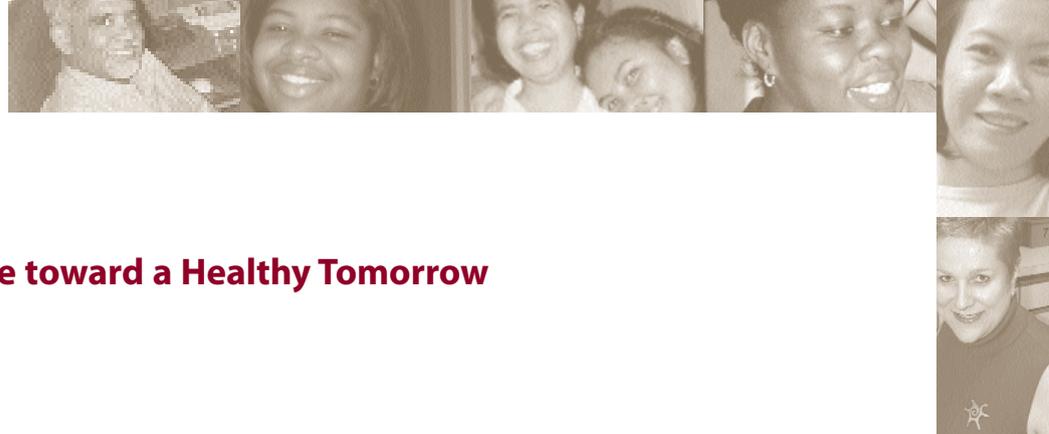
Maureen Kuyoh
Senior Program Coordinator
FHI/Kenya, Family Planning and
Reproductive Health Program

"It is very gratifying to feel that, through my work, I am making a contribution towards alleviating suffering among people and helping them improve their health."

Peter Mwarogo
Deputy Director
FHI/Kenya







Working with Today's Young People toward a Healthy Tomorrow

More than a quarter of the world's population—1.7 billion people, or six times the population of the United States—are 10 to 24 years of age. Young people are being seriously affected by HIV/AIDS:

- About half of new HIV infections are among 15- to 24-year-olds
- More than 7,000 young people are infected by HIV each day—one every 12 seconds
- Young women are disproportionately affected, and in some African countries more than one in five young women is living with HIV/AIDS.

Young people also are overly burdened with other family planning and reproductive health challenges:

- One of every 10 births worldwide—15 million births a year—is to adolescents ages 15 to 19.
- Many of these births are high-risk and unintended, and younger girls are twice as likely to die in childbirth as women in their early twenties.
- As many as four million young women in developing countries have unsafe abortions each year.
- Seven of every 10 STIs occur among young people.

FHI's partnership with MTV

Music Television International, better known as MTV, is the world's largest youth-oriented television network. MTV reaches 374 million households worldwide—including 137 million people ages 12 to 34, more than 80 percent of them living outside the United States.

Recognizing this tremendous potential to reach young people in the developing world, FHI is partnering with MTV to promote healthy reproductive behavior and help prevent HIV infection among them.

Through our YouthNet and Implementing HIV/AIDS Prevention and Care (IMPACT) projects, we join the Bill and Melinda Gates Foundation and the Henry J. Kaiser Family Foundation in supporting MTV's *Global AIDS Campaign 2002: Staying Alive*. FHI is providing technical assistance to the campaign as it:

- Informs young people about how to protect themselves against HIV
- Promotes youth empowerment
- Combats stigma and discrimination against people with HIV/AIDS

- Encourages specific HIV-prevention behaviors.

The campaign was launched at the 14th International AIDS Conference in Barcelona in July 2002 and will continue through World AIDS Day, December 1, 2002. MTV contributed air-time for a global forum on youth filmed at the conference and will air public service announcements, produce an AIDS documentary, and use its various Web sites to promote the campaign. All programming will be free in developing countries.



YOUNG PEOPLE ARE ASSETS—NOT OBSTACLES

In marked contrast to an earlier time when public health professionals regarded youth as a “problem” to be solved, FHI believes that only young people themselves can effect changes that are critical to preventing HIV and STI infection and reducing the rate of unplanned pregnancy and unsafe abortion. By the end of 2001, FHI and its partners already had completed more than 70 studies and projects focused specifically on—and involving—young people.

Our biggest commitment to young people is YouthNet, a program FHI launched in October 2001 with a five-year award of \$85 million from USAID. YouthNet is dedicated to promoting reproductive health and HIV prevention among young people in selected developing countries. YouthNet’s partners include CARE USA, Deloitte Touche Tohmatsu Emerging Markets, Ltd., the Margaret Sanger Center International, RTI International, and a number of other international and in-country agencies.

Our youth-focused programs operate at all levels of society—individual, community, institutional, national, and international—and combine mutually supportive approaches that:

- Provide reproductive health and HIV education programs in schools and communities
- Mobilize young people and empower communities
- Use mass media creatively and widely to promote behavior change
- Overcome gender and age inequalities that increase vulnerability
- Build on existing capacities and scale up successful small programs to reach more young people.

The Healthy Adolescent Project in India

One-fifth of India’s one billion citizens are between 10 and 19 years of age. Almost 40 percent of young women between 15 and 19 are sexually active. With a median age at marriage of only 16 years, most young brides have children in their adolescence, putting their health and personal development at risk.

To improve the reproductive and overall health of young people in the West Bengal region of India, FHI formed the Healthy Adolescent Project in India (HAPI) in partner-

ship with the Family Planning Association of India, the World Association of Girl Guides and Girl Scouts (WAGGGS), and the Bharat Scouts and Guides Association (BSG). BSG is the largest youth network in India, with three million young members and vast experience in youth education that makes it an ideal vehicle for disseminating reproductive health information.

Launched on World AIDS Day 2000 and funded by the David and Lucile Packard Foundation,

HAPI has trained 900 peer educators to share health information with other youth. Those who successfully complete the HAPI program and reach the goal of 25 peers receive a badge and certificate. The program is available in English and all the local languages of participants. HAPI adopted a pilot project FHI conducted with WAGGGS in Egypt, Uganda, and Zambia, from 1997 to 2000. If HAPI is effective, FHI hopes to replicate it throughout WAGGGS’ 140-country network.



"I feel a personal debt of gratitude to FHI because they made it possible for me to move from being a peer counselor and performer to being a specialist in the field of social transformation by use of the performing arts. I am able to make an impact on the improvement of reproductive health and sexuality issues in my country and region, while teaching and facilitating others to do the same."

Michael Holgate
Edutainment/Technical Director
Ashe

Performing arts: Ashe

The exuberant young actors, dancers, and music-makers of the Jamaica-based Ashe Caribbean Performing Arts Ensemble and Academy thrill the body with their vibrant performances of Jamaican and Caribbean folk dances, songs, and drumming—while the messages they carry about health and respect for oneself and one's partners stimulate the mind.

Ashe—the name is a Yoruban word out of West Africa for "the strength, power, and talents within"—uses music, dance, and theatre to reach young audiences with life-affirming messages. Founded in 1993 by two Caribbean artistic directors and 70 talented young Jamaicans, Ashe's mission is to teach audi-

ences about healthy sexual behavior through delightful performances that combine education with entertainment in their colorful version of "edutainment."

FHI first partnered with Ashe in 1995, providing funding and technical assistance to develop "VIBES in a World of Sexuality." The songs and dances show the challenges and problems that arise when a group of teenagers on the brink of becoming sexually active are taken on a "journey" into the world of sexuality. USAID/Jamaica in 1998 supported FHI and Ashe in developing a family life curriculum and training guidance counselors, school nurses, and youth group leaders to teach young people about reproduc-

tive health. Since then more than half of Jamaica's guidance counselors have been trained. With our assistance, Ashe is now reaching out to parents and students throughout the Caribbean, and its materials have been adapted as far off as Namibia, Rwanda, and Senegal.







Improving Family Planning Services

As many as 120 million couples of reproductive age worldwide have an unmet need for family planning and a further 300 million are using a family planning method with which they are dissatisfied. Nearly 40 percent of all pregnancies are unintended. And more than 200 million additional women are expected to need contraception by 2015.

FHI has worked for more than 30 years to expand the availability, acceptance, and use of modern contraceptive methods and improve their safety, effectiveness, and quality. Not only do we evaluate new contraceptive technologies, but we also seek ways to improve the effectiveness of established methods—including the IUD, hormonal products, emergency contraception, sterilization, and male and female barrier products. We study such program dimensions as the economics of reproductive health services, how to improve provider practices, and what determines whether people will begin and continue to use contraception.

From research to practice

Research is of little value if results are not used to improve services. FHI's Research-to-Practice (RtoP) initiative promotes the increased use of research findings and evidence-based programs by ministries of health, international aid organizations, nongovernmental agencies, and individual service providers.

RtoP works with both local stakeholders and international partners to:

- Identify the most relevant global research results
- Prepare and implement strategic plans to disseminate research findings widely
- Identify local needs so programs can be appropriately tailored.
RtoP is already affecting service delivery in positive ways as we:
 - Work with our local and international counterparts to reintroduce the IUD in Kenya
 - Introduce a pregnancy checklist to be used where pregnancy tests are unavailable or unaffordable in helping to establish whether a non-menstruating woman is pregnant and to determine whether contraception is appropriate
- Ensure that our strategic alliances with such international bodies as the World Health Organization and International Planned Parenthood Foundation incorporate key research results into international service delivery norms and guidelines, and that FHI's research agenda reflects current research needs.





With the goal of improving family planning methods and services, we work closely with local, national, and international research and service delivery organizations in more than 100 countries throughout the world. Our partners include USAID, the U.S. Centers for Disease Control and Prevention (CDC), the U.S. National Institutes of Health (NIH), the World Health Organization (WHO), the Pan-American Health Organization, the United Nations Population Fund, and many USAID cooperating agencies.

HOW WE ARE HELPING TO MAKE A DIFFERENCE

Between 2001 and 2002 FHI conducted more than 200 different projects aimed at improving family planning methods and services around the world, including:

- Producing meta-analyses of randomized clinical trials of various contraceptive methods for use in evidence-based guidelines
- Preventing pregnancy and STI/HIV transmission among young adults in Jamaica by increasing the use of sexual and reproductive health services by adolescents
- Conducting operations research studies on such issues as adolescent reproductive health, integrating family planning services with STI prevention and treatment services, quality of care, and postabortion care
- Providing innovative education and clinical services for adolescent girls living as refugees in Egypt, Uganda, and Zambia through a unique peer education program that emphasizes reproductive health.

Improving vasectomy

Vasectomy is a popular contraceptive method in a number of countries and has the potential to be even more widely used given the safety, effectiveness, and affordability of the relatively simple procedure. Despite its popularity, there is uncertainty about the best vasectomy techniques, particularly in resource-constrained settings.

In December 2001, we reported results from a multicenter, randomized, controlled trial we conducted with EngenderHealth that compared vasectomy with and without fascial interposition. This technique, used in some

no-scalpel vasectomy (NSV) procedures, involves bringing the fascial sheath, or covering of the vas deferens, over one end of the cut tube to create a natural barrier between the two cut ends.

We found that 22 weeks after the vasectomy, 93 percent of the men who received the technique had reached zero or near-zero sperm counts—compared with 81 percent of the men who had not. FHI's presentation on fascial interposition at the December 2001 meeting of the Association of Reproductive Health

Professionals was awarded the Ortho Prize for "Best Original Research."

We are following this study with an observational study evaluating the effectiveness of cautery, another method of sealing the vas deferens. Some providers consider cautery the best method, but there has been little evidence so far in the clinical research to support it. We also have partnered with the Program for Appropriate Technology in Health (PATH) in exploring the feasibility of using handheld, battery-powered cautery devices for vasectomy in resource-constrained settings.



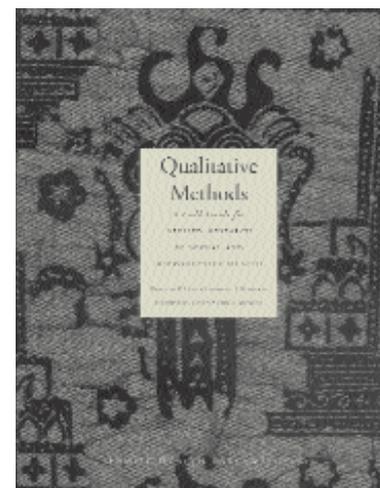
EXPANDING ACCESS

FHI's applied research identifies barriers to reproductive freedom and develops solutions to overcome the outdated practices and arbitrary restrictions that keep millions of women from using their preferred family planning method. Our contraceptive research and development broadens the range of safe, effective, affordable contraceptives for both women and men. And the timely, relevant, and accurate information we disseminate from our research—to service providers, health care policy-makers, researchers, and universities—helps ensure that national family planning and reproductive health policy and programs are informed by best practices and are based on sound scientific evidence.

Qualitative methods

FHI in 2002 published *Qualitative Methods: A Field Guide for Applied Research in Sexual and Reproductive Health* to address the lack of clear and systematic guidelines for planning and conducting qualitative research. Designed for professionals with formal training in the social sciences and experienced researchers, the guide describes the basic logic and rationale of decision-making in qualitative research; details practical strategies and methods for using research results;

and explains the complexities, advantages, and limitations of qualitative methods. It covers a wide range of topics—including theory; study design; data collection, analysis, and interpretation; and the use and dissemination of research findings. *Qualitative Methods* already is being used in schools of public health in the United States, Costa Rica, and Indonesia. Researchers in nongovernmental organizations in more than 35 countries also have requested copies.







Reinforcing Protection against Unwanted Pregnancy, STIs, and HIV

At least 130 million pregnancies a year are unintended. Each year 340 million new cases of curable STIs occur throughout the world. And more than five million people a year are infected with HIV, half of them women.

When used consistently and correctly, condoms offer “dual protection” against both pregnancy and STIs. Other contraceptive methods—such as the IUD, sterilization, or hormonal products—may be more effective against pregnancy, but offer no protection against STIs.

The best protection of all is a combination of two methods—known as dual method protection. FHI continues to lead the field in research on dual protection and dual method protection, focusing on three barrier methods—the female condom, the male condom, and microbicides.

THE FEMALE CONDOM

Because we believe women need better options for barrier contraception that they can initiate and control, FHI has become a leader in studying the female condom and other female-initiated contraceptive devices. Although the female condom is effective as a contraceptive, its use is limited in developing countries because it is not widely known or available and costs too much—up to 30 times the cost of the male condom.

FHI is studying ways to improve the availability, acceptability, and use of the female condom. Research is determining whether it is reusable, safe, and effective in contraception as well as in preventing STIs. Other research areas include availability, affordability, and ability to improve public health by being introduced and promoted among targeted high-risk populations.

Through our partnership with the USAID-supported Contraceptive Research and Development Program (CONRAD), FHI also is studying less-expensive female condoms and other barrier contraceptives women can initiate—including sponges, diaphragms, and cervical caps.





THE MALE CONDOM

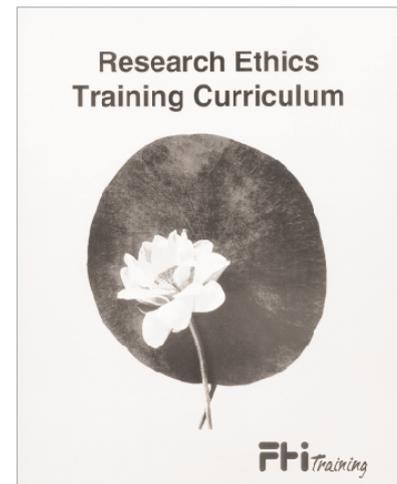
Because the male condom is a critical component in achieving widespread dual protection, FHI continues to evaluate a number of aspects of the male condom as we:

- Assure, through laboratory testing, the quality of 600 million condoms provided each year to USAID programs
- Investigate the acceptability and effectiveness of new plastic condoms
- Study ways to increase condom use through counseling and promotional messages
- Disseminate the latest research-based information to policy-makers and program leaders.

Research Ethics Training Curriculum

Ethical research principles are considered universal, transcending cultural, legal, and political boundaries. But despite increasing awareness of the need to safeguard the rights of people who are the subjects of research, little guidance exists on how to establish, monitor, and maintain high ethical standards. FHI's *Research Ethics Training Curriculum* addresses this need by strengthening overall understanding of and compliance with international standards of research ethics for working with human subjects. FHI developed the curriculum, with funding from NIH, USAID, and the Andrew W. Mellon Foundation, arranging review by experts

in research ethics and field testing in India, Kenya, the Philippines, the United States, and Zimbabwe. The CDC, NIH, USAID, and WHO have recommended the curriculum as an educational tool. The curriculum uses the latest adult-learning techniques to cover such areas as the principles of research ethics and informed consent, responsible conduct and supervision of research, international research ethics guidelines, and the roles and responsibilities of ethical review committees. It is available in various formats for self- or group study in English and Spanish. French and Chinese versions are forthcoming.





MICROBICIDES

A microbicide that is even 60 percent effective against HIV could avert at least 2.5 million infections over three years. Women could use a topical vaginal microbicide before sexual intercourse to protect themselves against STIs—a far more cost-effective approach than treating people already infected.

In February 2002, FHI investigators reported in the *Journal of the American Medical Association* that nonoxynol-9 gel does not prevent the transmission of gonorrhea and chlamydia, ending hopes that nonoxynol-9 might be a microbicide. The report generated wide U.S. and international media coverage. While disappointing, these important findings have increased the international effort to find a topical microbicide that will be effective against STIs, particularly HIV.

FHI's key contributions on microbicides are through our USAID-funded investigations, collaboration with CONRAD's Global Microbicide Project (funded by the Gates Foundation), and our leadership in the HIV Prevention Trials Network. FHI is also supporting the launch and efforts of the Rockefeller Foundation-sponsored International Partnership on Microbicides to bring a safe, effective, topical microbicide to market. With adequate funding and commitment, an effective microbicide could be brought to market as early as 2007—and FHI is well positioned to play a central role in its development.

The HIV Prevention Trials Network

Because HIV is transmitted through different routes in different populations at different times, a variety of prevention strategies is as essential to reducing HIV transmission at the population level as combination drug therapies are to lowering HIV "viral load" and improving an infected individual's prognosis. Computer models have demonstrated that multiple, mutually reinforcing HIV-prevention strategies will be the most effective way to slow the spread of HIV.

The HIV Prevention Trials Network (HPTN), established by the NIH, is a worldwide network of clinical researchers collaborating to evaluate

the safety and efficacy of prevention interventions other than vaccines. FHI and its partners, Johns Hopkins University in Baltimore and the Fred Hutchinson Cancer Research Center in Seattle, lead the group conducting research in 25 sites—16 international and nine in the United States.

HPTN coordinates domestic and international research that is led by multidisciplinary study teams of behavioral, clinical, epidemiological, and statistical scientists, with the ability to conduct cross-cultural comparisons. Guided by effective public health research principles for

research and practice, HPTN emphasizes active participation and collaboration by all interested parties—including investigators, governmental and nongovernmental entities, pharmaceutical manufacturers, and members of the communities from which study volunteers are recruited. HPTN's research on microbicides will determine whether two new microbicides—Buffer Gel and PRO 2000—now in development can prevent or reduce sexual transmission of HIV.

For more information about the HIV Prevention Trials Network, visit its Web site at www.hptn.org.





Helping People to Live with HIV/AIDS

Just as the needs of a person who has HIV/AIDS change over time, the services that person will need also change as the infection progresses. Comprehensive care—including services based in the home, community, and institutions—ensures that the needs of HIV-positive clients and their families are met at all stages of their illness. This helps people with HIV/AIDS live longer, healthier, more productive lives.

Programs that provide comprehensive HIV/AIDS care must be tailored to the culture, health care system, and human and financial resources of a particular country and community. Regardless of where they live, the needs of people living with HIV/AIDS typically include:

- **Medical**, such as diagnosis and treatment
- **Psychological**, such as emotional support and counseling
- **Socioeconomic**, such as practical support and support for orphans
- **Legal and human rights**, such as access to care and protection against discrimination and violence.

FHI is building on our international leadership role in piloting, testing, and scaling up prevention strategies and interventions by integrating them with care and support in a comprehensive approach. Through our USAID-funded IMPACT project, we provide technical assistance to a broad range of care and support activities in more than 20 countries throughout Africa, Asia, Eastern Europe, the Caribbean, and Latin America.





The Start program

More than 3,000 people—including villagers, traditional and political leaders, musicians and dancers, and government officials—turned out for the February 2002 launch of FHI's new Start program in the Manya Krobo region of Ghana. Their enthusiasm for FHI's new comprehensive HIV/AIDS care and support program reflected the magnitude of the HIV/AIDS problem in the region, one of the poorest and hardest-hit in Ghana.

The Start program is an initiative through which FHI and our partners are working with district health management teams and others to implement a comprehensive program of prevention, care, and treatment for people with HIV/AIDS and their immediate families. The program will offer VCT services and provide prevention and treatment for opportunistic infections in HIV-positive patients as well as ARV therapy for those with AIDS who meet specified criteria.

Start also will provide home-based care and referral services as well as support to programs for orphans and vulnerable children. Our initial goal is to provide ARV treatment to

1,000 people through the program. All efforts will be supported by prevention education to reduce risk and through care and support services. Start builds on the districts' strong community support structures and the equally strong commitment of health officials and traditional community leaders.

We will document the lessons learned from Start so they can be applied elsewhere in Africa and the rest of the world. The Start program will help us to learn how to deliver ARV therapy in resource-constrained settings, promote adherence to ARV regimens, maintain the quality and impact of comprehensive services, and reduce stigma. It will also teach us more about the cost comparisons of different approaches and levels of service integration.

The Start program exemplifies the way an FHI initiative can build upon the efforts of the government and rapidly expand by attracting key partners. Initiated with seed funds from FHI, Start has attracted a wide range of partners, including community organizations, international donors, and various units of the Ghanaian government. District health institutions and

nongovernmental organizations are contributing to the design and implementation of the program. Numerous other organizations are providing human, financial, or technical resources, including USAID, UNAIDS, UNICEF, the Noguchi Research Institute, and community leadership organizations such as the Queenmothers Association of Manya Krobo. Pharmaceutical companies also are helping by lowering the price of drugs and test kits.

We are developing Start programs in other African countries, using various means to introduce ARV therapy into comprehensive programs. In Mombasa District, Kenya, FHI is partnering with the Kenyan government, Management Sciences for Health, and the Population Council to strengthen the service capacity of the Coast Provincial General Hospital and two other primary health care centers to deliver ARV therapy.

In Rwanda, FHI will help strengthen care and support services by incorporating ARV therapy and building on the capacity of 12 existing sites that now provide VCT to more than 700 clients a week.



“Prevention, care, support, and treatment for those infected and affected by HIV/AIDS are mutually reinforcing elements of an effective response and must be integrated in a comprehensive approach to combat the epidemic.”

**Declaration of Commitment
U.N. General Assembly**

Special Session on HIV/AIDS, June 2001

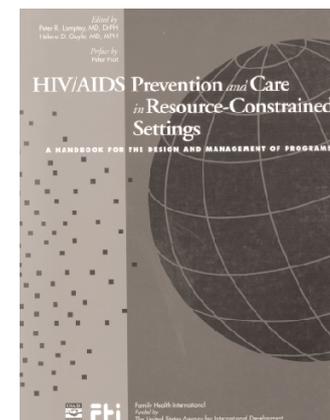
“This [Start] program and this fight against AIDS, this war—it’s not a fight, it’s a war—this war about AIDS is a community effort. It’s not going to happen without the vigorous commitment of the leadership in Manya Krobo. All my divisional chiefs, all the divisional queens, community leaders and everybody else, have made a concerted effort to make this thing work.”

Nene Sakitey II
Paramount Chief
Manya Krobo District

HIV/AIDS prevention and care in resource-constrained settings

FHI recognizes that providing comprehensive services—including prevention, care, support, and treatment—is a complex undertaking. To help those responsible for setting up and managing such programs, FHI commissioned leading experts throughout the world to provide state-of-the-art “how-to” information in their areas of expertise. Published in 2002, *HIV/AIDS Prevention and Care in Resource-Constrained Settings: A Handbook for the Design and Management of Programs* is

designed to help in the strategic planning, technical and programmatic design of interventions; management of public health programs; resource allocation; budgeting; and financial management. No matter where they are, program managers, technical and programmatic field staff, donors, international partner agency staff, health care providers, and field researchers will find the handbook useful in designing and managing the comprehensive programs needed today.





FORTUNATELY PREJUDICES CAN CHANGE

BUT HOW LONG WILL PEOPLE WITH HIV HAVE TO WAIT?

HIV can't be passed on by drinking with, living with or working with someone who has HIV. So why are we still so prejudiced against people with HIV? People with HIV are still people - parents, children,



Expanding VCT to Link Prevention and Care Services

Most people who are infected with HIV do not know it. They may be unwittingly infecting their partners or children. And they probably are not receiving the medical attention they need.

Although VCT services have long been part of prevention efforts in developed countries, they have only recently become more widely used in the developing world. But even these limited services are hampered by financial constraints, staff shortages, and concerns about confidentiality, stigma, and discrimination. VCT is an effective (and cost-effective) way to help people—HIV-positive and HIV-negative—change their behavior and lower the risk of transmitting or being infected by HIV. One FHI-sponsored study documented a 43 percent reduction in unprotected sex among people who were counseled and tested. VCT also provides an entry point for other HIV care, support, and prevention services. It enables clients to cope and make difficult personal decisions related to HIV/AIDS. And it helps combat stigma and discrimination against people who are HIV-positive.





HOW WE SUPPORT VCT SERVICES

FHI is supporting countries in developing culturally sensitive, client-centered VCT services by:

- Assisting communities to advocate for VCT with policy-makers and leaders
- Developing national guidelines
- Producing training materials and curricula for counselors
- Training counselors and laboratory personnel
- Promoting VCT through the media
- Providing quality assurance for both testing and counseling
- Linking VCT and other HIV services
- Managing, monitoring, and evaluating VCT services
- Scaling up effective VCT programs
- Selecting VCT sites as learning centers to gather and disseminate best practices.

FHI supports more than 70 VCT sites in 18 countries, serving tens of thousands of clients.

Scaling up VCT in Rwanda

Before 2000, the Centre d'Information Rwandais sur le SIDA (CRIS) was the only free-standing VCT site in all of Rwanda, located in the capital city, Kigali. Although other sites provided what they called VCT, testing was normally available without any access to counseling services. Blood samples from across the country were analyzed at one central laboratory, which meant it could take up to three months to obtain results.

Because of these obstacles, one in four clients tested in some sites never received their test results.

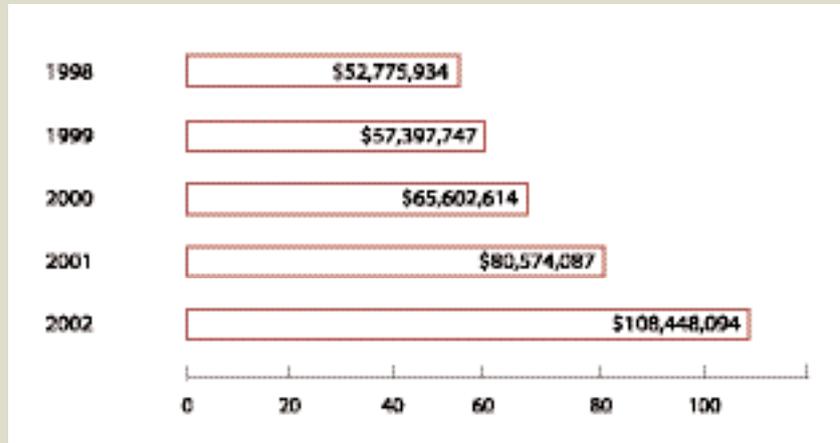
In 2000, USAID supported FHI in developing VCT sites in three district hospitals outside of Kigali. The services offered at the sites were unique in Rwanda in that they introduced full-time, individual counseling and provided anonymous, rapid testing. FHI also helped CRIS to improve its client record-keeping.

FHI helped to scale up VCT in Rwanda in 2001 by supporting nine additional VCT sites at hospitals, health centers, and the Association Rwandaise pour le Bien-Etre Familial (ARBEF), the local family planning affiliate. Altogether, the 12 sites in Rwanda supported by FHI served 40,310 clients in 2001. Using rapid tests to make results immediately available means that 98 percent of clients tested now receive their results—vital information they need to take care of themselves, their partners, and children.

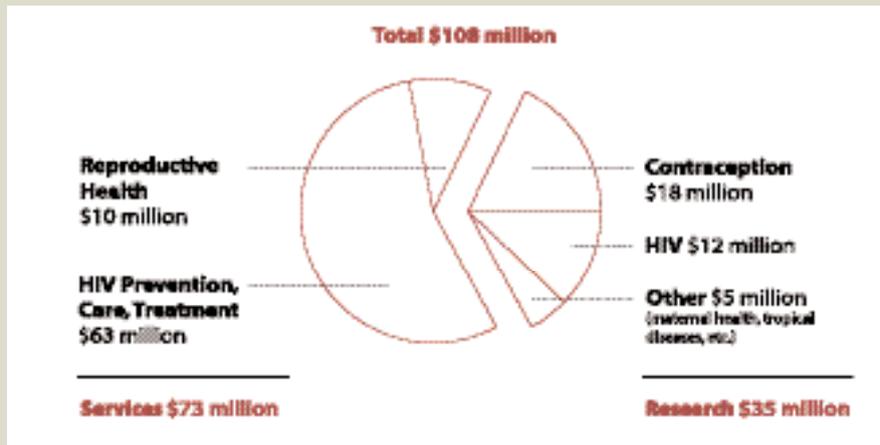


FINANCIAL HIGHLIGHTS

TRENDS IN EXPENDITURES



USES OF FUNDS IN 2002



STATEMENT OF FINANCIAL POSITION

SEPT 30, 2002

SEPT 30, 2001

Assets

Current assets:

Cash and cash equivalents	\$ 8,742,722	\$ 2,266,663
Short-term investments	923,318	1,046,118
Accounts receivable	5,799,908	7,410,895
Prepaid expenses	440,180	278,135
Pension forfeitures	510,929	437,929
Total current assets	16,417,057	11,439,740

Property and equipment:

Medical and office equipment	166,926	139,272
Leasehold improvements	796,079	542,942
Software	635,410	444,309
Electronic data processing	511,221	484,021
Automobiles	49,725	49,725
	<u>2,159,361</u>	<u>1,660,269</u>

Accumulated depreciation and amortization	(1,363,909)	(1,356,661)
	795,452	303,608

Total assets	\$17,212,509	\$11,743,348
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Liabilities

Current liabilities:

Accounts payable	\$ 2,307,265	\$ 2,848,894
Accrued salaries, payroll taxes, and fringe benefits	1,800,536	1,382,433
Unearned income	8,353,773	2,724,792
Total current liabilities	12,461,574	6,956,119

Net assets	\$ 4,750,935	\$ 4,787,229
Total liabilities and net assets	\$17,212,509	\$11,743,348



STATEMENT OF ACTIVITIES AND CHANGES IN NET ASSETS

	GOVERNMENT	NONGOVERNMENT	OTHER SUPPORTED ACTIVITIES	YEAR ENDED SEPT 30, 2002	YEAR ENDED SEPT 30, 2001
Revenues					
Contract and grant income:					
Agency for International Development	\$ 81,265,665	-	-	\$ 81,265,665	\$ 55,601,449
National Institutes of Health	16,074,412	-	-	16,074,412	16,713,178
	<u>97,340,077</u>	<u>-</u>	<u>-</u>	<u>97,340,077</u>	<u>72,314,627</u>
Contributions	-	-	950,050	950,050	1,000,050
Income from services	2,964,010	7,567,368	-	10,531,378	7,629,799
Investment income	-	8,815	103,448	112,303	259,959
Program income	11,570	377	199	12,146	17,976
Sublease income	-	-	(534,154)	(534,154)	(61,994)
Fixed fee (deduction) income	-	(65)	65	-	-
Total revenues, gains, and other support	<u>100,315,657</u>	<u>7,576,495</u>	<u>519,648</u>	<u>108,411,800</u>	<u>81,160,417</u>
Expenses					
Program services:					
Intervention, research, and evaluation	85,000,994	6,221,758	566,275	\$ 91,789,027	\$ 67,198,456
Supporting services:					
General and administrative	15,314,663	1,237,716	106,688	16,659,067	13,375,631
Total expenses	<u>100,315,657</u>	<u>7,459,474</u>	<u>672,963</u>	<u>108,448,094</u>	<u>80,574,087</u>
Change in net assets	\$ -	\$ 117,021	\$ (153,315)	(36,294)	586,330
Unrestricted net assets at beginning of year				4,787,229	4,200,899
Unrestricted net assets at end of year				<u>\$ 4,750,935</u>	<u>\$ 4,787,229</u>



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This report is dedicated to the memory of two remarkable people who, in different ways, made outstanding contributions to the development of Family Health International as a leading organization in international public health.

Widely known and well regarded in medicine and family planning, **Dr. Theodore (Ted) King** was respected internationally for his expertise in women's reproductive health and his dedication to clinical research and teaching. Ted joined FHI in 1991 after a distinguished term as chairman of an influential Department of Obstetrics and Gynecology at Johns Hopkins University School of Medicine, where he stimulated the establishment and funding of the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO).

Ted led Family Health International as President and Chief Operating Officer from 1991 until his retirement in 1998. He continued to serve the Board of Directors as an advisor and was appointed Chair in September 2000. He was deeply committed to building FHI's team of public

health researchers and technical advisors and pursuing the organization's goals of slowing the spread of HIV/AIDS and advancing the well-being of women and their families worldwide by improving access to quality reproductive health services.

Ted had a vision for FHI as an organization second to none in its technical excellence, both scientifically and programmatically. FHI's current strength as an international leader in reproductive health and HIV/AIDS interventions is a wonderful testimony to his dedication.

FHI is pleased to honor Ted by establishing the Ted King Educational Center at FHI's headquarters in Research Triangle Park, North Carolina. This center will be a daily reminder of Ted's leadership.



**Theodore M. King, MD, PhD
(1931-2002)**

While at the Burroughs Wellcome Company, **Dr. David Barry** became one of the coinventors of the first anti-HIV drug, AZT. Approved by the U.S. Food and Drug Administration in 1987, AZT was for years the only frontline drug against HIV, offering the first hope of prolonging the lives of people living with AIDS. Building on that groundbreaking achievement, David founded Triangle Pharmaceuticals in Durham in 1995 to further the clinical development of antivirals for the treatment of HIV and hepatitis B virus.

In the 12 years following his election to the FHI Board of Directors in 1990, David contributed immensely to the achievement of FHI's success through not only his great depth of knowledge and understanding of FHI's scientific and public health initiatives, but also through his expertise in corporate management and leadership.

In 2000, David exhorted FHI to "think big" by charting a new direction in the HIV/AIDS field. He was convinced that FHI had the international public health experience, scientific skills, and management capacity to marshal support for a holistic approach to the treatment and care of people living with HIV/AIDS in countries where resources for health care are seriously constrained. From this inspiring call evolved the Start program, launched in Ghana in February 2002 as described in this report.

FHI is pleased to honor David by establishing the David Barry HIV/AIDS Fellowship. This fellowship will help to assure that FHI will be able to attract scientists and other health professionals to work in one of its many HIV/AIDS-oriented programs.



**David Walter Barry, MD
(1943-2002)**

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