

**Report of a consultative meeting:  
Reconsidering the diaphragm and other cervical  
barriers in India**

**New Delhi  
June 10, 2008  
Packard Foundation**

Compiled by  
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**October 25, 2008**

## **I. Background and introduction**

A meeting was held in New Delhi at the offices of the Packard Foundation on Jun 10, 2008 to discuss the potential for re-introducing the diaphragm and other cervical barriers (CBs) in India. Various actors from diverse areas of sexual and reproductive health in India were brought together to reconsider the role of the diaphragm and CBs in India today.

The meeting was organized by Kathy Shapiro, an independent consultant working in sexual and reproductive health in India, and Lester Coutinho of the Packard Foundation. A number of issues prompted this meeting, including:

- The need for a broader range of contraceptive options in India, especially user-controlled options;
- the need for woman-controlled protection against HIV/STIs;
- an improved understanding of the role of the cervix as a target for STIs and HIV;
- the potential for cervical barriers to deliver vaginal microbicides for HIV prevention;
- the need to improve menstrual hygiene.

The goal of the meeting was to clarify the current status of the diaphragm in India and to outline appropriate strategies with which to proceed to make it available for use by Indian women.

The objectives of the meeting were to:

- Reach a shared understanding of current cervical barrier technology;
- Identify concerns about barrier methods, those currently marketed and experimental devices;
- Identify interested individuals, organizations and sources of support for CBs;
- Develop an initial strategy with which to move forward.

Lester Coutinho gave a short history of the diaphragm in India, which was introduced in India in the 1950's and somewhat available until the 1970's. At that time the diaphragm was part of the medical curriculum and was provided by gynaecologists. The diaphragm in India, as in the rest of the world, was gradually displaced by more effective 'modern' methods such as Oral Contraceptive Pills (OCPs) and the Intrauterine Device (IUD); it became unavailable in India, although women continued to express an interest in using it.

Kathy Shapiro made an introductory presentation on "Why reconsider cervical barriers in India?" and focused on the following specific issues:

- Research on the diaphragm in India
- High unmet need for contraception
- Limited contraceptive choice
- Women's need for discreet protection without partner negotiation

- Development of safer non-detergent spermicides
- New data on equal pregnancy protection of diaphragm + BufferGel (new spermicide) vs. N-9
- More evidence on acceptability and safety of the diaphragm in multiple populations
- Increased understanding of benefit of protecting specifically the cervix as a major target of STI/HIV infections
- Potential of cervical barriers to deliver microbicides and add to their effectiveness
- New easier-to-use, cheaper cervical barrier devices with no fitting required

In India, a study conducted in 1996 in Tamil Nadu by T K Sundari Ravindran et al showed very high user satisfaction and effectiveness of the diaphragm, while a subsequent study by the Indian Council of Medical Research (ICMR) published in 2000 had different results. The ICMR Task Force study evaluated contraceptive choice through the method-mix approach and 32,000 family planning clinic attendees at 31 Human Reproduction Research Centres were offered IUDs, OCPs, condoms, Norplant, tubal ligation, vasectomy, the today sponge and diaphragm with spermicide. 51 of the 32,000 women accepted the diaphragm and most of these discontinued within 3 months. The users cited discomfort, difficulty inserting and removing the diaphragm, cumbersomeness and messiness as reasons for discontinuation. The follow-up schedule was at one week to check placement and monthly to record side-effects and reasons for discontinuation. It was not clear what level of training and support was available to users, and provider bias was not measured. The unpublished conclusion of the ICMR was that low acceptance and early discontinuation implied the method was not acceptable. Besides the negative conclusion of the ICMR study, there was also the added difficulty of importing diaphragms for women who wanted them.

Currently the diaphragm is not part of the National Family Planning program in India. Although the regulatory situation is somewhat unclear and the diaphragm is not available, *there are no known barriers to its importation*. It was felt that NGOs, state governments, private providers, researchers could decide to use it in programmes or conduct research.

According to Dr. Suneeta Mittal of The All India Medical Institute (AIIMS), the diaphragm was in use about 30 years ago and women, especially uneducated, rural women had used it with no problems—in fact better than urban women as they had no hesitation in “touching their bodies”. However because of non-availability, use was gradually abandoned. Dr. M. E. Khan of the Population Council explained that they had imported 1000 diaphragms in the mid-1990’s and to support the study in Tamil Nadu, which showed high user satisfaction. Because of the bureaucracy, the diaphragms were blocked in customs for a long time and finally abandoned. He and Dr. Abhijit Das mentioned that Kalpana Mehta and others at the feminist organization Saheli had also provided Brazilian diaphragms for Rs. 400 in the late 1990’s, as it was a women-controlled method. The Brazilian diaphragms were used by some women, but the project was eventually abandoned although it was not clear why. The Family Planning Association of India (FPAI) has used the diaphragm in their basket of contraceptives in

the past. However, also due to unavailability, plus some complaints of vaginal irritation, problems in insertion and privacy issues, it was also discontinued. The diaphragm samples are still shown in counseling sessions amongst the basket of contraceptive choices.

## **II. Presentations**

### **A. International research on acceptability and efficacy for STI/HIV prevention - Nancy Padian of the Research Triangle Institute International (RTI), San Francisco the “Women’s Global Health Imperative (WGHI) via teleconference):**

Dr. Padian gave a brief background of WGHI and its goal of providing scientific leadership to help women and girls across the globe protect and improve their reproductive health. She listed the ongoing and completed WGHI studies on cervical barriers:

1. Methods to Improve Reproductive health in Africa (MIRA) Trial (Padian, van der Straten)
2. A Safety Trial of the Diaphragm and Cellulose Sulfate (DMS) in Zimbabwe (Padian; van der Straten)
3. Feasibility and Acceptability of Cervical Barriers among Vulnerable Youth in Africa (YCB) (van der Straten)
4. Duet for menstrual protection: A feasibility study in Zimbabwe (van der Straten)

The MIRA trial is the only randomized controlled trial which has looked at the diaphragm for HIV and STI prevention. In this study, more than 5,000 HIV negative women in Southern Africa were randomized to use either condoms and lubricant gel alone (control arm), or the diaphragm plus condoms and lubricant gel (intervention arm). All women were given intensive risk reduction counselling at every visit, free condoms and STI diagnosis and treatment. Condom use during the trial rose significantly in both arms but differential condom use was reported in the two groups, with women in the intervention group reporting condom use at last sex averaging 53.5% across all visits versus women in the control group averaging 85.1% use at last sex. No protective effect of the diaphragm was observed in women receiving the diaphragm plus lubricant gel and condoms, versus women receiving only condoms and lubricant gel. However the researchers note (Padian et al, Lancet, 2007) “Importantly, lower use of condoms in the intervention group than in controls did not result in an *increase* in HIV risk, suggesting that diaphragm use might have compensated for the difference in condom use.”

Dr. Padian reported another relevant outcome of the per-protocol analysis of the MIRA data on the protective effect of the diaphragm for gonorrhea and chlamydia. This analysis showed the diaphragm always used during the last 3 months had a protective effect of 39% against gonorrhea (almost reaching significance at 95% (CI 0.41-0.91) as well as a somewhat lesser protective effect for chlamydia. Although this analysis is not as rigorous as the intention-to-treat analysis done in randomized trials, it suggests, as

does the large body of observational data, that the diaphragm is protective against these cervical infections. *Therefore, despite the fact that MIRA did not show that the diaphragm protects against HIV, it still leaves the question of HIV protection open, and adds important evidence to a protective effect for cervical infections.*

### **B. User perspective study on the diaphragm in India – Dr. Sundari Ravindran (via teleconference from Kerala)**

Dr. Ravindran described in detail a user-perspective study that had been conducted by herself and a team of researchers from January 1995 to September 1996 in Tamil Nadu. The research question was “Is the diaphragm a suitable method of contraception for low-income women?” Two NGO out-patient clinics and one NGO in-patient facility participated in the study. All three facilities catered to low-income communities in the vicinity. The process followed was three-fold: pre-study, recruitment and follow-up. The pre-study phase was an intensive preparatory period that included community-based health education with a series of sessions on “learning about our bodies, sexuality, reproduction and contraception”; individual counselling for women at their doorsteps on contraception supported by pamphlets; an opportunity to see and handle the diaphragm and a baseline survey that collected information on socio-economic characteristics and contraceptive history of all currently married women aged 15-49 years.

In the recruitment phase interested women were invited for a fitting in one of the three clinics; detailed guidance and practice in the clinic with the gynaecologist was provided on insertion, removal, washing and storing. Women were given time to consider their decision and come back if they decided to use the diaphragm, at which time they gave informed consent. They were assured of medical termination of pregnancy (MTP) free-of-cost in cases of method failure.

The third follow-up phase included weekly follow-up for six-months at user’s homes; in-depth interviews of women at home at six months with two to three sessions on consecutive days. There was additional follow-up at 18 months to document discontinuation and failure.

97 women enrolled and started using the Milex Wide-Seal diaphragm made of silicon with Shur-Seal contraceptive jelly. All women in the study were low-income; 91% lived in one-room-kitchen tenements; 66% had no bathroom or toilet at home; 35% were illiterate and only 30% were engaged in paid work; and 85% women were married to manual labourers. 68% had one living child and 25% had two living children. 60% were 15-24 years old and 25% were 25-29 years old. 68 out of the 97 women planned to use the method for 18-24 months for spacing; 27 intended to use it for less than 1 year before sterilization; while only 2 intended for long-term use. At 18 months, 95 women were available for follow-up. 67 were still using the method; 7 had undergone sterilization; 14 had discontinued to go in for the next pregnancy and there was one dissatisfied user because of bad fit. There were no pregnancies during the first year of use. Six women became pregnant after one year of use and none opted for MTP because of the intention to have more children.

Users showed high degree of satisfaction with the method. Insertion and removal became easier over time, and less of a problem because of the training process. Cleaning and storing was done carefully and messiness of the jelly was not felt to be a problem because it made insertion easier. The lack of bathrooms and toilets was not considered an issue and women asked interviewers “How do you think we manage our menstrual periods?” Low frequency of sexual intercourse (92 out of 97 women reported sex once a week or less frequently because of lack of privacy, early walking to fetch water, tiredness for the woman and hard manual labour by the husband) and mostly pre-planned sexual intercourse made diaphragm usage easier. The absence of negative health consequences was most appreciated. The user-controlled nature of the diaphragm, the use “as and when necessary”, and not being pressured to “accept” the method were considered important features. Husbands were supportive because of the absence of side effects; also because abstinence was the only method considered suitable when the diaphragm was not an option. Women reported fear of the side effects of OCPs and the IUD, and dislike of the condom.

According to Dr. Ravindran, relevance of the diaphragm in the present context in India is high because use of reversible methods is very low with sterilization being used by 77% of Indian women, 95% in Andhra Pradesh and 90% in Karnataka. The median age at sterilization is decreasing: 26.6 years in NFHS-1, 25.7 in NFHS-2 and 25.5 in NFHS-3. Women are without viable options for reversible methods and she sees a niche market for barrier methods especially for young women who want to space births, and women for whom sterilization was contraindicated.

The issues to consider are availability of the diaphragm, cost, availability of an ideally packaged safe spermicide, provider bias against the method because it is user-controlled and considered less effective. Also important are the political will for investment of resources in education and counseling that have beneficial health outcomes beyond only effective contraception.

During the discussion Dr. Ravindran explained that the same diaphragm was used for one year. In the study, the diaphragm was used for contraception and not for STI/HIV protection or as a menstrual cup. The study disproved many assumptions about the diaphragm especially for poor women. It was felt that the pre-study phase and the preparatory work that had been done on “learning about their bodies” and the lack of pressure to use the method were crucial to the success of the study. Dr. M.E.Khan said that the study had been a good one showing high utilization, however, there was a key question on how this might bear out in the public sector given the intensive counselling requirement. Dr. Ravindran said that the counseling could be made briefer and the component on learning about their bodies and reproductive health could be included in the adolescent sexual and reproductive health education. Dr. Ravi Verma said that the study was conducted within the context of high contraceptive prevalence in Tamil Nadu and infrastructural issues such as male involvement and social norms would need to be addressed if the diaphragm were to be introduced in other settings.

### **C. Technical update on the diaphragm and cervical barriers – Kathy Shapiro**

Ms. Shapiro explained the rationale for protecting the cervix – the increased fragility of the cervix makes it more susceptible to disease and infection (gonorrhea, chlamydia, Human Papilloma Virus, or HPV, HIV) compared to the vagina. She explained the following different types of cervical barriers:

#### ***Chemical barriers***

- ***Spermicides:***
  - a) Nonoxynol 9 (N-9) – an effective spermicide, used for years for contraception which has a detergent action, disrupts cell membranes and is unsafe for women at high risk of STI/HIV because it was shown to increase HIV transmission among women having sex multiple times a day;
  - b) Buffergel – a new spermicide which acts as a buffering agent – it maintains low vaginal pH in the presence of sperm and is safe for high and low risk women. It has been proven safe and effective against pregnancy but is not yet FDA approved.
  
- ***Microbicides:***
  - Failed products – N9 has microbicidal properties but is unsafe; cellulose sulfate probably unsafe, SAVVY not effective, maybe unsafe with frequent use;
  - Carraguard – found not to be protective, but is safe;
  - Pro2000 Gel – Phase II-III trials ongoing for HIV/STI prevention;
  - Buffergel – Phase II-III HIV/STI prevention trial ongoing; very safe, pivotal Phase III trials for contraception with diaphragm successfully completed; FDA approval expected in approximately 2 years
  - ARV-based products such as tenofovir gel – trials are ongoing

***Physical barriers*** (diaphragms, caps, cups and female condom) such as diaphragms and caps have been in use since the 19<sup>th</sup> century. Caps are smaller and cover only the cervix and include new devices such as the FemCap and the Lea’s shield. The menstrual cups such as Instead (disposable), Mooncup (reusable) are being used by millions of women in the US and Europe to manage menses without the use of cloths, pads or tampons. The female condom was successfully introduced in 2004 in India and has been gaining popularity.

***Diaphragms:*** She presented samples of five different diaphragms and discussed their characteristics. The five diaphragms included the following:

- All-Flex Diaphragms (Ortho, J & J) – Rubber or latex dome with spring in rim, 9 sizes, 55-95 mm and requires fitting, most widely used, marketed for years, cost approximately Rs. 500.
- Milex Wide Seal Diaphragm – silicone dome with skirt, 8 sizes (requires fitting), distributed in US, Canada, Europe, Asia and the Middle East, cost approximately Rs. 2700.
- Semina – made of clear silicone, 6 sizes (60-85 mm), available in Brazil, cost unknown.
- SILCS (PATH) – made of silicone, one size (no fitting), pre-shaped ring with finger cup, Status of Phase II-III contraceptive trials with N9 and BufferGel ongoing; FDA approval expected in 2009-10, High acceptability in men and women, Estimated cost is unknown at this time- still in pilot production only.
- Duet (ReProtect)- made of polyurethane, one size (no fitting), designed to go with Buffergel but can be used with/without other products, estimated cost is Rs. 65, made to double as menstrual cup, acceptability is high, status is Phase II-III contraceptive trials, approval expected by 2010.

More information on these can be found on the CBAS (Cervical Barrier Advancement Society) website at <http://www.cervicalbarriers.org/>. The newer devices are made of latex, silicone, polyurethane; some are one size, with no fitting required, easier to use. These have over-the-counter potential, can be cheaper and are reusable for 1-2 years. The effectiveness of the diaphragm for pregnancy prevention in typical use was 16% (16 pregnancies/100 W/Y) and perfect use was 6 %. Observational data from various studies show protective effects of the diaphragm for STI protection. The diaphragm also has important potential to deliver vaginal microbicides currently being investigated for HIV prevention for women, and to improve their effectiveness by providing both a physical and chemical barrier together. The BufferGel Duet combination for example, is designed specifically to do this (although it can be used alone).

Ms. Shapiro briefly described the ongoing diaphragm trials in Latin America, Africa and the US, which are primary acceptability studies and evaluation of provider perceptions amongst physicians and nurses. Important trials to begin soon are the Madagascar multi-site 4 arm randomized controlled trial to assess the effectiveness of the diaphragm and BufferGel in the prevention of gonorrhea and chlamydia (funded from the United States and conducted by USAID, CONRAD, CDC), and the Zimbabwe acceptability study of the Duet of continuous use vs. intermittent use with lubricant gel.

### **III. A. Discussions - Relevance to India**

Priya Nanda of the International Coalition for Research on Women (ICRW) facilitated the discussion on relevance of the diaphragm to India. Dr. Ravindran and Dr. Mandakini Parihar felt that women in India wanted to continue to use the diaphragm and there was a need for user-controlled, non-hormonal, reversible contraceptive methods. The group felt that not enough is known about women's needs and it was important to understand the needs of different groups for example, monogamous women, migrant women, women in

different geographic areas, urban, rural, etc. through in-depth interviews and focus group discussions.

There was a discussion on the types of population to target for the diaphragm and whether the focus should be on the diaphragm as a contraceptive or as disease prevention or both. There were differing views on this. Some experts such as Dr. Abhijit Das of the Centre for Health and Social Justice and Malabika Roy, ICMR, felt that the diaphragm should be introduced as a contraceptive method for the broader general population, within “trusted relationships” because of its efficacy, user-controlled nature and “usage as and when necessary” and not be labeled as only for high-risk groups such as sex workers. They felt that would stigmatise the diaphragm and give it a “bad image”. Kathy Shapiro described her exploratory discussions with groups of sex workers in Kolkata and Karnataka and said that sex workers are very interested in the possibility of the diaphragm as a back-up method to use when clients, and especially regular partners refuse to use a condom. Although some sex workers are using the female condom, many do not have access to it, and in most cases it cannot be used without a partner’s knowledge. Dr. Suneeta Mittal felt that the diaphragm should be positioned as a spacing method and if STI/HIV prevention were the focus, then the female condom could be utilized. Other experts felt that it could be used both for contraception and disease prevention and could be used for all types of women – monogamous and high-risk group women. Mr. Richard Steen felt that proper “positioning” of the diaphragm was important and it should be done discreetly among high risk groups to avoid stigmatizing its use among other women.

There were concerns raised on the diaphragm – especially the lack of doctors and nurses trained on the method. Dr. Mittal commented that nurses and doctors in training today have probably never even seen one. Some felt that more information is needed before implementing the results of the study in Tamil Nadu on a national level. Dr. Roy commented that in the ICMR study as the diaphragm was only one of the methods provided in a mix of methods, she is interested in ICMR commissioned studies potentially through 2-3 rural and semi-urban clinics at Federation of Obstetricians and Gynecologists Society of India (FOGSI) and FPAI, and 7-8 district hospitals with different populations of women. These could focus on user-perspectives, effectiveness and acceptability with both the provider and client. She noted that the Ministry of Health and Family Welfare (MOHFW) could fund those studies.

Dr. Khera of NACO felt that there was potential for introducing the diaphragm as part of strengthening the STI component of HIV prevention in NACO’s program. They are in the process of re-branding STI services to “Sexuality and Reproductive Health services”. STIs are currently on the agenda of the RH and HIV programs therefore there is an effort to integrate programs. He also stressed that 40% of HIV positive women in India were infected primarily by their husbands who were clients of sex workers. He said that the diaphragm could also be used for HIV positive women. Dr. Mandakini Parihar of FOGSI felt that the diaphragm had a huge potential as a dual protection and could potentially be utilized in the PPTCT program for discordant couples.

Ms. Shapiro clarified the use of the diaphragm in high risk women such as sex workers as a back-up method to condom use, and not something to take the place of condoms, since this would leave the vagina exposed to infection, and that sex workers she interviewed brought up this issue with her spontaneously. For example, a sex worker could insert the diaphragm before starting work with clients, or before going home to her regular partner/husband. She would insist on condom use with partners as the only proven method of protection against HIV, but if she were coerced into sex without a condom, she would at least have some protection from the diaphragm against disease and pregnancy. It is in their married/regular relationships that sex workers often have the greatest difficulty negotiating condom use and protecting themselves.

Dr. Amar Jesani stressed the importance of cost and the need for better accessibility and availability as currently the diaphragm would need to be imported and the cost could be prohibitive; therefore local production would need to be explored to lower the price as in the case of the female condom that is currently being manufactured in India. He cautioned against playing into “the hands of pharma companies.” Ms. Shapiro agreed and noted that this was the reason that a representative of the Hindustan Latex Trust (manufacturer of female condoms in India) was present at this meeting.

Another idea suggested was to introduce the diaphragm in social marketing programs, however, that idea raised concerns especially on adequate health education and counseling. It was also felt that if given free, the method may not be taken seriously as was in the case of high wastage for the condom.

Monique Mosolf of the U.S. Agency for International Development (USAID) felt that it was important to involve the national government at this stage and suggested holding a half-day consultation with the government.

Anne Philpott, of the UK Department for International Development in India (DFID) gave advice on how to introduce a new product in any country based on her earlier experience with the female condom. She said it was important to have studies conducted in different settings – community, provider-based and over the counter studies in different populations. It was important to take the introduction of a product slowly and gradually to provide answers on cost effectiveness, user perspectives etc. She said it was important to be “pragmatic and realistic” and not rush into the introduction of a product because if there was “crash and burn”, people and policy makers would always remember the failure. She noted that even a 3-4% uptake of a method was important. The positioning of the product was key – positioning the products perhaps in different ways to different populations.

### **III B. The Way Forward**

Ms. Tilly Sellers of the Program for Appropriate Technology in Health (PATH) facilitated group discussion on the way forward. Anne Philpott felt it was important to conduct research in different situations or settings with different groups of women parallel to looking for funding. Kathy and Priya Nanda felt that it would be useful to

conduct research and build evidence through 2-3 small Tamil Nadu type studies. Priya Nanda stressed the importance of doing a stakeholder analysis that assessed the political climate, policy making, and initiated dialogue with feminist groups. Renuka Motihar stressed the need to think through a process and action plan for re-introducing the diaphragm instead of having ad-hoc activities.

According to Renuka Motihar and Lester Coutinho, potential donors who could be tapped for funding included the Gates Foundation, the Buffet Foundation, American India Foundation, Sri Ratan Tata Trust, Dorabjee Tata Trust. Agencies such as Population Services International (PSI) and International Planned Parenthood Federation (IPPF) had received large funding from the Buffet Foundation and could be tapped for potential funding. Bilateral agencies such as USAID, DFID, and the European Commission would be involved in the process and may include the diaphragm under their other funding mechanisms. The United Nations Population Fund (UNFPA) was also interested to be part of the process. Advocating for Reproductive choice (ARC), the coalition of nine NGOs who are advocating for contraceptive methods, funded by Packard Foundation with FPAI as the current secretariat could be tapped for potential joint funding. A mapping of donor agencies should be undertaken. Richard Steen said that WHO would consider support if the need came from the community, for example from the DMSC Sex Worker Collective in Sonagachi.

#### **IV. Next steps**

Possible outcomes of the meeting that were discussed included:

- ICMR could start feasibility studies at FOGSI and FPAI clinics with support from agencies such as ICRW;
- Further discussions could be held with Dr. Khera, NACO, for possible use within programs with HIV positive women and women at high risk for HIV and STIs with a focus on integrating disease prevention and FP and reproductive health services;
- Discussions with Dr. Jayalakshmi to provide feedback on the meeting of June 10 and pursue the interest of MoHFW;
- Discussions with UNFPA on interest and activities around the diaphragm;
- Circulation of a report of this meeting to participants and interested parties;
- Formation of a core working group on the diaphragm and CBs in India;
- Development of an action plan to include coordinated activities among interested parties (including such activities as stakeholder mapping and analysis, research needs and opportunities, manufacturing, involvement of government, NGOs and communities, mapping of potential donors etc.)

Meeting agenda and participant list are below.

## Agenda

Meeting on Diaphragm and other cervical barriers in India

10<sup>th</sup> June 2008, Tuesday

Venue: B 5, Second Floor, Greater Kailash Enclave II, New Delhi 1000048

- 0930 – 0940            Welcome and Introductions  
*Lester Coutinho, Packard Foundation*
- 0940 – 0955            **Presentation 1**  
Why reconsider the Diaphragm in India?  
*Kathy Shapiro, Consultant, SRH/ HIV, New Delhi*
- 0955 – 1010            **Presentation 2**  
User perspectives on the diaphragm in India  
*Sundari Ravindran, Achuta Menon Centre, Trivandrum*
- 1010 – 1025            **Presentation 3**  
International research on acceptability and efficacy for STI/HIV  
prevention – update and current research questions  
*Nancy Padian/ Suneeta Krishnan, Women's Global Health Imperative  
RTI, San Francisco*
- 1025 – 1040            **Presentation 4**  
Technical update on modern cervical barrier methods  
*Kathy Shapiro, Consultant, SRH/HIV, New Delhi*
- 1040 – 1115            Discussion
- 1115 – 1145            Tea/ Coffee break
- 1145 – 0100            **Group Discussion: Relevance to India**  
*Facilitator: Priya Nanda, ICRW*  
(Discussion will focus on population groups that could potentially  
benefit from access to cervical barriers; and concerns about re-  
introducing cervical barriers)
- 0100 – 0145            Lunch
- 0145 – 0315            **Group discussion: The Way Forward**  
*Facilitator: Tilly Sellers, PATH*  
(Discussion will focus on the next steps for taking process forward,  
identifying key individuals and institutions to lead this process; and also  
explore opportunities for financial support)
- 0315 – 0330            Summing Up and Closing Remark  
*Lester Coutinho, Packard Foundation*

## List of Participants\*

<b>Name</b>	<b>Organization</b>
Dr. Malabika Roy	ICMR
Dr. Vasantha Muthaswamy	ICMR
Dr. Ajay Khera	NACO
Dr. Richard Steen	WHO SE Asia Regional Office
Dr. Po-Lin Chan	WHO India Country Office
Amrita Kaslan	Hindustan Latex Foundation Trust (HLFPPT)
Anne Philpott	DFID
M. E. Khan	Population Council
Abhijit Das	Centre for Health and Social Justice
Mandakini Parihar	FOGSI, Mumbai
Suneeta Mittal	AIIMS
Bindiya Nimla	FPAI, Mumbai
Jutika Banerjee	ARC
Tilly Sellers	PATH
Monique Mosolf	USAID
Amar Jesani	CEHAT, Mumbai
Nancy Padian*	RTI, USA
Sundari Ravindran*	Achuta Menon Institute, Kerala
Suneeta Krishnan*	RTI
Renuka Motihar	Consultant
Priya Nanda	ICRW
Ravi Verma	ICRW
Lester Coutinho	Packard Foundation
Kathy Shapiro	Consultant

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\* Participation via teleconference.