

Only a few years ago, communities of Buddhist monks were the main source of care for Thais with AIDS. Now, Thailand has a national program offering antiretroviral treatment to its HIV-positive citizens, the first of its kind in Asia.



WASHIRAPORN SURAMAYTHANGKON

EXPANDING ACCESS TO AIDS TREATMENT

Operations research in Thailand and Kenya addresses critical program issues

At the closing session of the 2002 international AIDS conference at Barcelona, Dr. Paul Farmer, director of the pioneering Partners for Health AIDS treatment program in rural Haiti, made a prediction: "This is the summer when everything will change." After nearly a week of intensive conference discussion about the global imperative to bring antiretroviral treatment to developing countries, his message couldn't have been more clear.

As it turned out, Dr. Farmer was right. In the past two years, broadening access to antiretroviral treatment has taken center stage in global HIV/AIDS efforts. Health experts, activists, researchers, government and community leaders, and programmers are now committed to a future where even the poorest countries—which have 90 percent of the world's HIV infection—will be able to offer life-saving AIDS medications to their citizens, a prospect unthinkable even a few years ago.

Improving AIDS Treatment Programs

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The Population Council implements the Horizons Program in collaboration with the International Center for Research on Women, the International HIV/AIDS Alliance, the Program for Appropriate Technology in Health, Tulane University, Family Health International, and Johns Hopkins University.

HORIZONS' PORTFOLIO OF TREATMENT STUDIES

- India:** Assessment of Adherence to Treatment and Sexual Risk Behavior Among HIV-positive Patients Receiving Antiretrovirals in Pune
- Kenya:** Introduction of Antiretrovirals in the Management of HIV-infected Individuals in Mombasa
- Thailand:** Reducing Dropouts and Increasing Adherence Rates among People Living with HIV/AIDS on HAART in Northern Thailand
- Zambia:** Using Community Structures to Support ARV Adherence and Prevention for People with HIV in Lusaka and Ndola

What has turned the once-unthinkable into reality was a historic combination of advances in drug formulation, dramatically lower costs, ambitious funding mechanisms, and new political will. While only a few years ago, AIDS patients on highly active antiretroviral therapy (HAART) had to juggle complex regimens of dozens of pills a day, treatment has been simplified to—in some cases—as few as two daily pills, not only less expensive but much easier to follow. The cost of standard antiretroviral medications has dropped precipitously, and the development of inexpensive generic versions holds the promise of even greater affordability. Governments, donors, and the public health community, encouraged by these changes, are showing a renewed energy and commitment to treatment. As funding becomes available through the Global Fund to Fight AIDS, Tuberculosis, and Malaria, President Bush's Emergency Plan for AIDS Relief, and the WHO campaign to treat 3 million by 2005 (the "3 by 5 initiative"), treatment programs are rapidly being implemented in some of the poorest regions of the world—regions hit hard by AIDS.

Given the rapid pace of these developments and their potential for saving millions of lives, operations research has become critically important. Understanding how to design these new programs so that they are acceptable, functional, accessible, and cost-effective is key to their success. For example, making sure that patients adhere to their medication schedules—in other words, take all of their medication correctly and on time, every day for the rest of their lives—is essential to avoiding viral resistance and the development of deadly new HIV strains that make standard drugs ineffectual. Reducing stigma and discrimination—fear of which can prevent indi-

viduals from getting an HIV test and, if positive, from seeking treatment and support services—is also critically important. Promoting safer sex behaviors among HIV-positive individuals can help them avoid infecting others and re-infecting themselves.

Working with research and program partners around the world, the Horizons Program has launched a broad portfolio of operations research to increase global knowledge about implementation of HIV/AIDS treatment programs in sub-Saharan Africa, Asia, and Latin America. This issue of *Horizons Report* describes operations research in Thailand—which has an established HAART program—and Kenya, where treatment programs are still in their infancy. Critical treatment issues—adherence, protective behavior, monitoring and follow-up, and more—are a focus, as well as the research approaches needed to better understand how to solve treatment-related problems.

Thailand's Access to Care Program

In 2000, Thailand became one of the first developing nations in the world to provide HIV-positive citizens with HAART. The Access to Care (ATC) program—which began with only 1,200 clients—now serves tens of thousands throughout the country, with plans for ongoing expansion until all Thais who need treatment are covered.

To advise the Thai government as it prepares to further scale the program up, the Community Medicine Department of Chiang Mai University and the Ministry of Public Health conducted a rapid Situation Analysis of the program six months after its inception in the five northern provinces of Chiang Mai, Chiang Rai, Lampang, Lamphoon, and Phayao, where HIV prevalence is among the highest in

Thailand. With financial and technical support from Horizons, which is funded by the U.S. Agency for International Development, a research team examined operational issues in each province at one large provincial hospital and two district hospitals housing ATC treatment clinics, each serving anywhere between five and 50 clients.

A Situation Analysis assesses the capacity of a health system to deliver services. The researchers concentrated on delivery and logistics, the technical capacity of service providers, the quality and coverage of counseling services, follow-up and monitoring, patterns of client adherence to the drug regime, and the involvement of support groups for HIV-positive people, community-based organizations, and NGOs.

One hundred clients receiving treatment and 33 family caregivers were interviewed for the study; one client/service provider interac-

providers attended a second meeting, where a counseling manual was distributed.

The research team analyzed staff capacity by examining job responsibilities, technical competence, confidence to do their job, experience, and attitudes throughout three stages of treatment: preparation (before clients received HAART), the first month of the drug regimen, and the months of treatment following the first month.

Most of the health providers surveyed—95 percent—had positive attitudes about the ATC program overall, citing the value of its services to clients and their improved health as a result of receiving HAART. Yet 76 percent felt that their workload had increased since the program began, although most acknowledged that the problem could be resolved by adjusting their schedules to allow them to concentrate more on the ATC program.

“As professionals dedicated to healing, most are very enthusiastic about working with ATC clients,” said Dr. Simon Baker, Horizons/Population Council, a principal investigator. “They have seen people who were about to die join the program and make a remarkable recovery, so they feel these drugs are making a world of difference.”

Despite their enthusiasm for the program, the providers faced a number of obstacles. During the first month of HAART, more than half of the ATC clients interviewed had adverse side effects, and about half of the doctors and pharmacists and a third of the nurses reported that they did not feel confident about managing side effects.

After the first month, the occurrence of side effects decreased and the health of clients began to improve. Yet one-third of care providers, particularly nurses and pharmacists, reported difficulties in interpreting lab results. Nurses and counselors also reported difficulties in managing the increasing dropout rate during this stage and in motivating clients to continue their medication.

Counseling Roles

Counseling was available at all 15 of the ATC clinics in the study, covering four basic topics: taking medications, recognizing and managing side effects, general health, and safer sex

Using operations research to design treatment programs that are acceptable, functional, accessible, and cost-effective is key to their success.

tion was also observed at each of the 15 clinics. In addition, the team interviewed 20 clients from nine clinics who had dropped out of the program. To gain the perspectives of service providers, researchers interviewed five counselors, nine doctors, eighteen nurses, ten pharmacists, five hospital directors, eight NGO representatives, and one provincial health officer.

Capacity of Care Providers

To prepare care providers—doctors, nurses, pharmacists, and counselors—for the start of the ATC program, the Thai Ministry of Public Health sponsored two days of training. Physicians and pharmacists received guidelines on the medications they were to dispense, while nurses and counselors (the latter for the provincial hospitals only) were trained in how to prepare patients to receive HAART. After the first six months of the program, care

behaviors. While only the five provincial hospitals had trained counselors, all ATC nurses had received training in counseling and provided most of the counseling at the ten district hospitals.

During the preparation phase, nine of 12 hospitals reported that they provided clients with counseling or information two weeks before starting HAART; the other three hospitals started this on the same day that clients began their treatment. Counseling during this phase lasted an average of 26 minutes for individual counseling and 40 minutes for group counseling.

But confidence in providing individual counseling varied by topic and type of health provider. About two-thirds of the nurses, counselors, and pharmacists involved in counseling felt very confident about providing general health counseling. But nearly half did not feel confident about providing safer sex counseling. While 70 percent of pharmacists expressed confidence about counseling patients about the side effects of antiretroviral drugs, only a third of the nurses and none of the counselors did.

Over the course of the first month of treatment, counselors played less of a role than did nurses and pharmacists, largely because the focus of counseling shifted to discussing reactions to the medications and difficulties with adherence. After the first month of treatment, care providers reported that far fewer clients needed counseling because many had worked out problems with dosages and side effects. By this stage, professional counselors had generally stopped working directly with clients; nurses and pharmacists were responsible for most of the counseling.

Quality of Counseling

The researchers also assessed the quality of counseling by observing one-on-one counseling sessions between clients and doctors, nurses, and pharmacists that took place after the preparation stage. These were generally quite short, seven minutes on average. In two-thirds of the observations, service providers started the session by asking clients about problems they were having, but the researchers found that few attempted to draw out details of these problems or to provide



information. Care providers tended to ask questions that required simple yes/no answers, and if the client was not forthcoming, the discussion ended quickly. Researchers noted that little effort was made to motivate clients to continue to adhere to medication.

The experience was quite different during a group counseling session observed in a provincial hospital moderated by an NGO representative that focused on the practical problems clients face when taking antiretrovirals. With the help of a nurse, a health worker, and a pharmacist, who each contributed to the discussion from the perspective of their expertise, the two-hour session examined issues and problems in considerable detail, and the clients appeared comfortable about discussing their feelings with the group.

Despite the inconsistency in quality of counseling observed by the research team, an overwhelmingly high percentage of clients expressed satisfaction with all of the counseling services—both one-on-one and group—that they had received. Nearly all of the clients (98 percent) felt that they had had an opportunity to talk about their problems, and 95

percent expressed satisfaction that their problems had been solved.

“One important cultural factor to consider when analyzing quality of counseling is that Thais do not have the same tradition of counseling found in Western nations, or even a strong understanding of the concept,” said Dr. Baker. “Health providers often ‘talk at’ clients or provide information rather than engage in an interactive discussion of personal issues that is key to good counseling.”

Supporting Adherence

To encourage adherence to HAART, the ATC program implemented follow-up procedures—including letter or phone reminders and home visits—to help clients follow medication regimens and remember clinic appointments. But less than half of current clients and dropouts reported that they had been reminded by letter or phone call of an upcoming appointment.

The rate of home visits was quite low. Among clients receiving HAART, 20 percent reported that a health care provider visited them at home in the first month of starting HAART, and 11 percent reported that a vol-

unteer from a support organization for HIV-positive people had visited them. After the first month, home visit rates for clients dropped to 5 percent. Among treatment dropouts, the home visit rate was 30 percent for the first month and 25 percent after the first month, higher percentages that likely reflect the greater problems experienced by dropouts.

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The researchers also found several patterns of nonadherence to HAART that included missing tablets (13 percent had missed a tablet within the last four days), not taking the medication on time (28 percent), and not following instructions (25 percent). Clients reported different reasons for their nonadherence. “Busy with other things” and “away

from home” were the major reasons ATC clients gave for forgetting to take medication. Overall, ATC client records revealed a high dropout rate of 30 percent after six months among all of the hospitals in northern Thailand. The primary cause for this was the severity of side effects that clients experienced.

Among clients interviewed in this study who were receiving HAART, 15 percent reported severe side effects and 43 percent reported moderate side effects in the first month.

Among dropouts, though, the rate of severe side effects in the first month was 40 percent and of moderate side effects was 20 percent. After the first month, none of the clients who adhered to HAART reported severe side effects, compared to 29 percent of those who dropped out.

Clients who adhered to their HAART regimen reported marked improvements in their health. Ninety-seven percent reported improved physical health, while 90 and 96 percent reported that their mental health and general outlook on life, respectively, had improved. In addition, 78 percent said that their ability to work had also improved.

Community Involvement

All 15 hospitals in the study had support groups for clients. Ten of the hospitals included representatives of groups for HIV-positive people in establishing selection criteria for clients to receive HAART. At eight hospitals, organizations of people living with HIV/AIDS helped follow up HAART clients; eight hospitals also invited HIV-positive individuals to talk about their own HAART experiences to those starting therapy. People living with HIV/AIDS also undertook home visits, as requested, but this was informally arranged. During these visits, they provided physical and emotional support, offered information on taking medication, encouraged clients to adhere to their medication schedules, and made referrals to other services. Half of the representatives of organizations for HIV-positive people surveyed for the Situation Analysis reported that they had received training in antiretroviral medication from international NGOs.

Fifteen representatives of support organizations for HIV-positive people were inter-

Nearly half of nurses, counselors, and pharmacists did not feel confident about providing safer sex counseling.

viewed for the study, and several made suggestions about how to improve the ATC program. These included strengthening procedures for follow-up and for home visits, giving organizations of people living with HIV/AIDS a more active role in client monitoring and follow-up, and offering them more training in counseling and health education.

Most health providers agreed that members of these organizations could play an important role in monitoring patients' medication adherence at home, and also felt that they should moderate group counseling sessions because they understand what clients are experiencing as they begin and continue HAART treatment.

The study also found that NGOs involved in HIV/AIDS treatment, care, and support provided a wide range of services to ATC clients. During home visits, NGO outreach workers provided physical and mental support and health care education, made referrals, and accompanied clients who were unable to get to health care facilities by themselves. They sometimes also provided education and counseling on taking antiretroviral medication. Some of the NGOs were involved in strengthening the capacity of HIV-positive volunteers to undertake outreach activities and provided technical and financial assistance to newly established groups of people living with HIV/AIDS.

Next Steps

According to Dr. Baker, the Situation Analysis has been well received by ATC program managers and public health officials in Thailand, who have used its findings to consider how to improve provider skills and confidence; patient counseling, monitoring, and follow-up; and involvement of local resources to strengthen adherence to HAART and reduce the dropout rate.

"The study has been a useful tool to help health officials in northern Thailand identify where they need to put resources and energy to make ATC even better," he said. "Even program managers whose clinics were not involved in the study are familiar with the study's results and use them to advocate for improvement."

With support from the Ministry of Health and hospital officials, Horizons and its study

partners have used the insights gained from the Situation Analysis to design an intervention study. The research evaluates the use of

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practical guidelines and a strengthened clinic counseling intervention with and without a peer-based component to reduce dropout rates and promote short- and long-term HAART adherence.

To date, health providers have been trained to provide HAART counseling and to use practical guidelines detailing how to provide antiretroviral medication, and HIV-positive volunteers have been trained to provide peer education to individuals taking these medications. In Chiang Mai, Chiang Rai, Lampang, and Lamphoon provinces, 45 hospitals have been assigned to one of three study arms. In Arm 1, the health providers will provide HAART counseling and use the practical guidelines. Arm 2 will be the same as Arm 1, except that HIV-positive volunteers will provide peer education, counseling, and support at the hospital and at clients' homes. Arm 3, the control arm, will provide the standard of care that is currently offered in the ATC program. Findings from this research will be used to help strengthen and scale up the ATC program throughout Thailand. 

This article was written by Margaret Dadian in conjunction with the study team, which includes Dr. Simon Baker, Horizons/Population Council, and Dr. Ratana Panpanich, Community Medicine Department, Chiang Mai University. For more information about this study, please contact Dr. Philip Guest at Philip@popcouncil.th.com or Dr. Panpanich at rpanpani@mail.med.cmu.ac.th. To receive e-mail notice when new publications about this research and other studies are available, sign up at www.popcouncil.org/horizons/signup.html.

INTRODUCING HAART IN AFRICA

Kenyan study tests adaptation of TB treatment strategy

Although 70 percent of the world's HIV infections are in sub-Saharan Africa, antiretroviral treatment programs have only recently arrived in a few African countries and most are still on a small scale. Scarce financial resources and poor infrastructure have been among the barriers to broader introduction of HAART, but as the cost of the drugs drops, policymakers, public health officials, and international donors are launching new initiatives to bring treatment to more HIV-positive Africans throughout the continent.

Achieving high levels of adherence to the HAART regimen is critically important worldwide. But special challenges must be overcome in African settings, where scarcity of clinical facilities and trained staff makes it difficult to

reach clients with the ongoing support and monitoring needed to ensure that HAART clients take all of their medications correctly and on time. These problems have long been at the heart of debates about the feasibility of introducing HAART in Africa and other high-poverty regions with extremely limited clinical infrastructure.

To explore these issues, Horizons and its research partner, the International Center for Research on Health (ICRH), are conducting operations research on a pilot program to provide HAART through public hospitals and clinics in Mombasa, Kenya. The study will examine changes in sexual behavior and perceived levels of stigma and discrimination among clients before and after beginning HAART, as well as the cost and cost-effectiveness of the program. Initiated by the United States Agency for International Development and the Kenyan Ministry of Health and implemented by Family Health International and Management Sciences for Health/RPM Plus, the program will serve as a learning site for new HAART programs in public health facili-

DAART nurse Raymond Ngwai and community health worker Zilfa Mohammed of Likoni Health Centre, one of the clinics in the study.



AVINA SARNA

ties in Kenya and other African countries.

Project partners took several steps in designing the research study to ensure its acceptability among such stakeholders as health workers, provincial health authorities, donors, and community members. In April 2002, a planning workshop with stakeholders was held to discuss the government's antiretroviral treatment framework, national treatment guidelines, and the Mombasa program intervention. Participants discussed key programmatic issues, including strengthening capacity, logistics and supplies, and local ownership. Stakeholders agreed on a workplan for the implementation of the intervention and appointed steering and scientific committees.

Operations research as an essential component of the design of a service delivery program was the focus of a special session at the meeting. Study investigators presented the research methodologies that could be used and led a discussion of potential operations research topics.

Adapting DOT for HIV/AIDS

As a result of these workshop discussions and later meetings with the scientific committee, program implementers, and health service providers at potential service delivery sites and at a local home-based care project, the research team decided to focus on a modified "directly observed therapy" approach to promote adherence to the medication regimen.

Directly observed therapy (DOT) is a treatment strategy originally developed for tuberculosis patients, who must take all their medication consistently and on time for up to nine months to rid themselves of the infection. The standard DOT approach uses health workers or community volunteers to "directly observe," that is, watch clients to be sure they take each dose of their medication. These strict levels of adherence are critical to maintaining public health, because TB is highly contagious and can mutate into drug-resistant strains if proper treatment protocols are not followed.

"Like TB, AIDS requires consistent adherence to avoid viral resistance and protect health, and DOT has proven to be very effective in helping TB patients maintain their treatment schedules," said Dr. Avina Sarna,

Horizons/Population Council. "One big difference, though, is that unlike TB therapy, antiretroviral medications for HIV/AIDS must be taken for life."

A DOT strategy for AIDS treatment is called DAART, for "directly administered antiretroviral therapy." A DAART program includes observation of patients taking their medications, but less often than for TB.

Service Preferences

Study investigators conducted formative research in 2002 to determine whether clients and health workers would prefer a modified DAART program where health workers visit clients at home for observation, or one where clients go to the clinic for observation. Researchers interviewed 38 clients currently using HIV/AIDS care services and conducted focus groups with 31 health workers from six health facilities in Mombasa.

Health workers were divided about the acceptability to clients of home-based follow-up and observation. Most health workers in three of six focus groups felt that clients would accept frequent home visits, but others felt that stigma and confidentiality posed major barriers because of fear of outsiders and concern that frequent visits might compromise confidentiality.

More than 75 percent of clients expressed a greater preference for follow-up and observation at a health facility rather than at home. Greater confidentiality and a perception of better care and monitoring of the disease were the most frequently cited reasons.

"The hospital is equipped with drugs and



PAUL MUNYAO

A team of community health workers who trace clients who do not appear for observed treatment or to pick up medication.

A community health worker talking to a client.



PAUL MUNYAO

medicines that can be used to help me, [and] the environment is conducive—there is confidentiality, unlike at home,” said a 22-year-old female respondent.

Seeking Support

When asked about family members accompanying them to the clinic, over three-quarters of clients surveyed wanted to bring a family member to the clinic. In response to researchers’ queries about their expectations of family members, two-thirds of all clients said they would like assistance in taking medications, while almost a quarter said they would ask

More than 75 percent of respondents preferred follow-up and monitoring at a health facility rather than at home.

family to pick up medications at the health facility. Help with listening to the doctor’s instructions, encouragement, help getting to the clinic, and financial help are other forms of assistance clients said they would expect to receive from family members.

Researchers also asked about support organizations for people living with HIV/AIDS to determine if such groups could be used to help clients adhere to HAART. Unfortunately, almost two-thirds of the clients interviewed had not heard of their local groups, and 82 percent had not received any support from such groups. While two-thirds of the respondents said they were willing to let other people with HIV/AIDS visit them at home, others had serious reservations.

Health workers from all focus groups knew of support groups in Mombasa, and some had worked with them. The majority of health workers felt that support group members could help clients with medications by motivating and encouraging clients, becoming role models, and accompanying them to the hospital.

Study investigators also asked about clients’ experience with an existing preventive therapy program for tuberculosis, pneumonia, and other infections. Almost half of the clients in the study were taking preventive therapy, and 89 percent of those reported adhering to it regularly. When asked to cite reasons for their regular adherence, respondents cited help from family members most frequently, followed by reminder cues or calendars, clear instructions and directions, determination to take medications correctly, and the incentive of feeling better as a result of taking medications.

Intervention Study

The intervention study, which began in late 2003, compares the adherence of clients in a modified DAART program with that of a control group of clients receiving HAART that is not directly observed. Clients are randomly assigned to participate in either the DAART program or the unobserved HAART program. Both groups will receive adherence counseling.

Given patients’ preference for follow-up in a health facility, those in the intervention group are required to visit a DAART observation site twice a week for a period of six months, to pick up medications and to have their drug intake observed. Like all HAART clients, DAART clients are also required to visit a central treatment site monthly for routine treatment monitoring. The study will follow all clients for 12 months.

While DAART clients can fulfill their twice-weekly monitoring at the four original treatment sites, they may prefer to visit one of three satellite observation sites closer to home for observation and to pick up medication. To better serve clients who work during the day, some centers open early. A tracing system using community health workers was also created to help look for clients who do not show up as scheduled for observation, medication pick-ups, or appointments.

The research team has begun recruiting clients for the intervention. So far 44 and 47 individuals starting HAART have been recruited into the DAART and unobserved HAART arms of the study, respectively. (The study aims to recruit approximately 230 clients altogether.) The median age of clients recruited thus far is 37 years. Sixty-one percent of these clients are women, evidence that women are taking advantage of care services. Eighty-five percent of clients reported that they disclosed their HIV status to someone; 58 percent disclosed to partners. More than 90 percent of clients reported moderate to high levels of satisfaction with family support.

Though it is too early in the study to report findings about long-term adherence, clients in both arms who have completed four months of follow-up have reported significant improvement in quality of life measures in the domains of physical functioning, role functioning, cognitive functioning, and pain and energy levels. Data also show an improvement in depression scores for clients in both arms completing six months of follow-up.

The study will also look at client experiences with stigma, both perceived and enacted, and at fear of stigma at home, work, and in the health care facilities.

Sexual Behavior

To investigate changes in sexual behavior, participants from the DAART group and the unobserved HAART group answer questionnaires at the beginning and end of the study about their number of current partners, condom use, history of STIs over the past year, disclosure of status to partner, and partner's HIV status. Clients also answer questions on attitudes and beliefs about HIV and AIDS, infectivity with HIV when taking HAART,

use of condoms, and optimism related to taking HAART. A subset of 25 randomly selected subjects will participate in in-depth interviews to closely explore attitudes and perceptions related to high-risk sexual behavior.

In addition, researchers are investigating sexual behavior among a cross-sectional sample of clients not taking HAART. The sample currently includes 37 men and 73 women receiving preventive therapy for tuberculosis and other infections; the research team plans to recruit a total of 230 clients for this study arm. Preliminary results from this small sample show that less than half of the respondents reported having sex in the last six months, and 90 percent of these respondents had sex with a regular partner. But a greater proportion of women (50 percent) than men (29 percent) did not know their regular partner's HIV status. Condom use at last sex with a regular partner was high overall, but the proportion of women who did not use a condom at last sex with a regular partner was twice as great as that for men (26 percent vs. 12 percent). Also, half of the women thought their regular partners had other partners, while only 6 percent of men thought so of their regular partners. These data show that in HIV care settings, gender-sensitive education and counseling are imperative to facilitate partner communication and safer sexual behaviors.

Interim results on the different facets of the study are expected in early 2005, while final study results are expected in June 2006.

An antiretroviral treatment training manual developed for health workers in the intervention study is available on the Horizons website at (www.popcouncil.org/horizons/mombasatrnrgmnl.html). A research update on the formative portion of this study is available at www.popcouncil.org/pdfs/horizons/mombasaform.pdf. 

This article was written by Sherry Hutchinson in collaboration with principal investigators Avina Sarna, Horizons/Population Council; Mark Hawken, ICRH; and Johannes van Dam, Horizons/Population Council. For more information on this study, please contact asarna@pcindia.org or markhawken@icrhkenya.org. To receive e-mail notice when new publications about this research and other studies are available, sign up at www.popcouncil.org/horizons/signup.html.

STUDY IN BRIEF

SOUTHERN BRAZIL “Health on the Road”: Designing HIV/AIDS Programs for Truck Drivers

Highly mobile populations—transport workers, migrant laborers, construction crews—are key targets for HIV/AIDS prevention and treatment efforts but can be difficult to reach with traditional programs. Truck drivers, for example, spend much of their time on the road, where—away from family and community—they may be particularly vulnerable to HIV and other STIs. Their mobility also makes it less likely that they will receive sustained prevention messages from public health campaigns, or use “stationary” health and prevention services that are appropriate for fixed populations.

In Brazil, the government has sought to meet the challenge of providing effective prevention and care to the country’s hard-to-reach and mobile populations. In 2001 the Ministry of Health asked the Brazil office of the Population Council to perform an HIV/AIDS-related assessment in six border towns to inform policymaking and identify appropriate interventions for disadvantaged border and mobile populations. Interviews were conducted in towns bordering Bolivia, Colombia, Peru, Argentina, Uruguay, and Paraguay; study findings identified truckers in southern Brazil as a key population to target with

HIV/AIDS activities. The assessment provided the framework for a new Population Council and Horizons collaborative intervention study focused on truckers, which was designed and implemented in collaboration with the Municipal STI/AIDS Program of Foz do Iguaçu, in southern Brazil.

The formative research revealed that truck drivers view their trucks as both their life investment and their home away from home, and thus do not like to venture far from them. Since trucks may remain parked at border checkpoints for anywhere from one day to several weeks waiting for documents and for cargo to clear customs, setting up mobile prevention and care services in the customs area was a logical choice for reaching as many truck drivers as possible.

Truckers also expressed substantial concerns about HIV-related stigma and discrimination during the formative research. They were highly sensitive about being labeled as rootless vectors of disease and felt that targeting truckers with an HIV/AIDS program would only reinforce negative stereotypes.

“Although many truckers have regular or casual partners while on the road, they see themselves as devoted family men, who call home often and take their family responsibilities very seriously,” said Dr. Juan Diaz of the Population Council, one of the study’s principal investigators. “Because of their self-perception as dedicated family men, truckers feel that any blame for spreading disease is unwarranted.”

Alerted to these concerns, the study team developed a holistic intervention to provide HIV and STI services. Rather than focusing solely on HIV and STIs, the Saude na Estrada (“Health on the Road”) Project provides additional services, including blood pressure measurement, glucose testing, and educational activities focusing on common health issues for truckers. The project has also

The mobile health unit created for truckers just outside the customs area at Foz do Iguaçu, on the border between Brazil and Paraguay.



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implemented health activities in partnership with other municipal health programs, such as the nutrition and vaccination program, and has sought out sponsoring organizations, including Goodyear Tires.

This mobile health unit, located inside the customs area of Foz do Iguaçu, serves the dual purposes of allowing truckers to feel less stigmatized for seeking health services while also recognizing their mobility and catering to their unique needs. More than 800 Brazilian and foreign truckers received services during the first months of activities in 2004, including a behavior change message campaign that uses brochures and radio spots, condom distribution, and voluntary HIV counseling and testing, as well as testing and treatment for other STIs. Educators provide outreach to the truckers in the customs station, leading discussions about truckers' health and HIV/STI risk. Truckers who test positive for HIV are referred to a specialized network within the Brazilian health system for treatment and care and are followed by the project for one year to document their experience and ensure that they receive the care they require.

The Saude na Estrada Project continues until 2005, when Horizons and the Brazil office of the Population Council will publish results of its study. If successful, the researchers anticipate that national and local authorities will continue the program to offer these essential services to truck drivers and ultimately expand to other sites.

For more information about this study, contact Julie Pulerwitz at jpulerwitz@pcdc.org. To receive e-mail notice when new publications about this research and other studies are available, sign up at www.popcouncil.org/horizons/signup.html.

Alison Clarke

Horizons at the XVth International AIDS Conference in Bangkok

Horizons researchers and partners will be presenting results from the program's broad portfolio of studies at the conference in Bangkok. Seven oral presentations and 37 poster presentations will cover such topics as:

- Antiretroviral treatment programs.
- Prevention of mother-to-child HIV transmission.
- Voluntary counseling and testing.
- Programming for young people.
- Prevention.
- Stigma and discrimination.

If you're coming to the conference, please visit the Horizons and Population Council display (Booth 70) at the exhibition hall.

For more information about Horizons presentations at Bangkok, go to www.popcouncil.org/mediacenter/bangkok/homepage.html.

Horizons Report

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