

PD-ABL-211

13th Annual Report



AIDSCAP

1994

ANNUAL

REPORT

Project 936-5972.31-4692046
Contract HRN-5972-C-00-4001-00

USAID



The AIDS Control and Prevention (AIDSCAP) Project, implemented by Family Health International, is funded by the United States Agency for International Development.

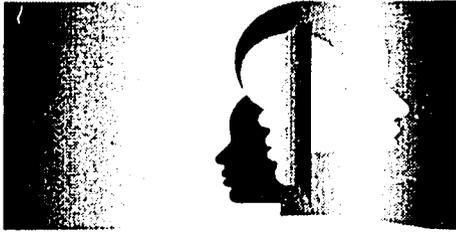


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AIDSCAP

INTRODUCTION/

SUMMARY

OF

ACTIVITIES



ACRONYMS

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AIDS	acquired immune deficiency syndrome
AIDSCAP	AIDS Control and Prevention Project
AIDSCOM	AIDS Public Health Communication Project (former USAID-supported project of the Academy for Educational Development)
AIDSTECH	AIDS Technical Support Project (former USAID project of FHI)
AMREF	African Medical and Research Foundation
AWI	AIDSCAP Women's Initiative
BCC	behavior change communication
BCCU	Behavior Change Communication Unit
BFA	Bangkok Fights AIDS
BMA	Bangkok Metropolitan Administration
BRU	Behavioral Research Unit
CAPS	Center for AIDS Prevention Studies, University of California at San Francisco
C&T	counseling and testing
CBO	community-based organization
CDC	Centers for Disease Control and Prevention
CDS	Centres pour le Developpement et la Santé (Haiti)
CEDPA	Centre for Development and Population Activities
CPI	core prevention indicators
CPLM	Condom Programming and Logistics Management
CSM	condom social marketing
CSW	commercial sex worker
DAC	Department of AIDS Control (Ethiopia)
FHI	Family Health International
FP	family planning
FY	fiscal year
HIV	human immunodeficiency virus
IEC	information, education, and communication
KABP	knowledge, attitudes, beliefs, and practices
LA/C	Latin America/Caribbean Region
MCH	maternal and child health



AIDSCAP

MIS	management information system
MOE	Ministry of Education
MOH	Ministry of Health
MPSC	multiple partner sexual contact
NGO	nongovernmental organization
OCP	Office of Country Programs
ORW	outreach worker
OYB	operating year budget
PAHO	Pan American Health Organization
PATH	Program for Appropriate Technology in Health
PHE	peer health educator
PIF	process indicator form
PSAPP	Private Sector AIDS Policy Presentation
PSI	Population Services International
PVO	private voluntary organization
RA	resident advisor
REDSO	Regional Economic Development Services Office (USAID)
STD	sexually transmitted disease
TAG	technical advisory group
TA	technical assistance
TB	tuberculosis
TIR	targeted intervention research
TWG	technical working group
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States dollars
WHO	World Health Organization
WHO-GPA	World Health Organization-Global Programme on AIDS



HOW TO USE THE TABLES IN THIS REPORT

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The baseline indicator tables summarize information across multiple target populations reached by the program. In general, "high-risk" populations reflect STD clinic attenders, commercial sex workers and their clients, the military, and other mobile male populations, as well as male and female populations identified as practicing "multiple partner behavior" — commercial or otherwise. "Low-risk" populations include youth, the general population, ANC clinic attenders, and general workplace populations.

The summary process data reflects cumulative information reported to the regional and headquarters offices as of October 24, 1994, and does not necessarily represent total project activity to date for any country or subproject activity. Data inclusion details can be found as footnotes to each table.

Data on condoms distributed only reflects those distributed directly through AIDSCAP projects. It does not include condoms available to target groups through other channels.

More extensive data description and discussion is available for selected countries (e.g. Jamaica and Thailand) and will be available shortly for the remaining priority countries.

Additional (and unique) process indicators are available for all country subprojects on request.



SUMMARY OF ACTIVITIES

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During the project's third year, AIDSCAP made significant progress toward achieving its objectives, meeting or surpassing most of the targets that had been set for year three. The original project plan called for AIDSCAP to implement comprehensive programs in 12 to 15 countries, and the most recent annual work plan projected that 131 subprojects would have been initiated by the end of fiscal year 1994. At the end of FY94 comprehensive HIV/AIDS prevention programs were underway in 20 countries and 183 subprojects had been completed or were being carried out, primarily by local community-based groups and other nongovernmental organizations.

By the end of FY94 AIDSCAP had educated 1.9 million people about HIV/AIDS, trained 41,000 people in AIDS/STD prevention, and sold or distributed 75 million condoms.

Progress toward meeting the following major project objectives was particularly notable during FY94:

**IMPROVED
MULTIDIMENSIONAL
PROGRAMS
DESIGNED,
IMPLEMENTED
AND EVALUATED**

Multidimensional programs that integrate behavior change communication, condom programming, and control of sexually transmitted disease (STD) have been designed in 17 designated "priority" countries to date. Fifteen of these designs resulted in AIDSCAP implementing comprehensive priority country programs. Three of these priority country program designs were finalized in Honduras, Tanzania, and Indonesia during FY94. AIDSCAP also has worked with governmental and nongovernmental agencies in three of its "associate" countries, including Zimbabwe, South Africa, and Nepal, to develop comprehensive, large scale HIV/AIDS prevention programs.

Twelve priority country programs are being implemented, and the three recently approved programs in India, Indonesia, and Honduras will begin in FY95. The Rwanda program was suspended in April 1994 due to civil unrest in the country, but AIDSCAP and its partners continue to work with Rwandans through a pilot project in refugee camps in Tanzania.

AIDSCAP also is working in 13 associate countries worldwide and five "areas of affinity" in Asia. Assessments completed during FY94 in Mongolia, Sri Lanka, and Guatemala are likely to lead to requests for future program implementation. During the past year AIDSCAP established an office in the Philippines to carry out a program to strengthen surveillance and improve STD control.



AIDSCAP

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All priority country programs have detailed evaluation plans that specify how each program and each subproject will be monitored and evaluated. Country staff and their partners are completing baseline assessments and regularly collecting and reporting standardized evaluation data.

**FINDINGS FROM
BEHAVIORAL
RESEARCH
APPLIED TO
INTERVENTIONS**

AIDSCAP uses formative research to design interventions. In most cases this research consists of focus group discussions or surveys to determine appropriate approaches or mechanisms to reach target groups and develop relevant and effective messages. In addition, AIDSCAP is conducting large-scale research in four sites to explore local knowledge of STD and health-seeking behavior. Information gathered through this research will help improve STD diagnosis, treatment and prevention services.

Results of four large behavioral research grants initiated under the AIDSTECH Project have been disseminated in the countries where the research was conducted (Indonesia, Haiti, Jamaica, and Uganda) and internationally through conference presentations. Papers describing the research results are being prepared for refereed journals.

Results from the Indonesian study, conducted by researchers from the University of Michigan and Udayana University to assess sexual practices and condom use among sex workers and their clients in Bali, were used to design an AIDSCAP-funded intervention study to promote safer sex and distribute condoms in brothels. A study by Johns Hopkins University and Chiang Mai University in Thailand is using qualitative and quantitative methods to conduct intervention trials to increase condom use by sex workers and military conscripts.

**CRITICAL POLICY
ISSUES RESOLVED**

AIDSCAP has made significant progress in many countries by working with decision makers to encourage recognition of problems with policy dimensions and plan approaches for formulating policies that encourage and support HIV/AIDS prevention.

In the Dominican Republic, for example, AIDSCAP assisted the National AIDS Control Program in analyzing existing epidemiological data and developing a presentation of projections based on the data. This presentation to senior policy makers about the potential impact of HIV/AIDS in the Dominican Republic stimulated adoption of legal safeguards for people with AIDS and a requirement that all government ministries set aside funds in their budgets to address HIV/AIDS. In Brazil AIDSCAP worked with a number of organizations to reduce federal taxation on condoms, which will increase access to condoms among lower-income groups. As a result of AIDSCAP-sponsored study tours for Indonesian



policy makers to Thailand, a core group of AIDS activists is working to develop HIV/AIDS policies for Indonesia.

MEETING NEW CHALLENGES

As the AIDSCAP Project has grown, new challenges have emerged. During FY94 the project's response to these challenges has focused on improving program effectiveness, managing AIDSCAP's conversion from a cooperative agreement to a contract, and supporting special initiatives to address the evolving epidemic.

During the third year of the project, management efforts focused more intently on improving programs in the field. Strategies for increasing effectiveness include decentralizing program management to country and regional offices, strengthening capacity building efforts with nongovernmental organizations and other partners, actively seeking feedback from the field, and disseminating lessons learned from the AIDSCAP experience to date.

Reviews of country programs by joint USAID-AIDSCAP teams have proved an effective mechanism for seeking feedback from the field, addressing problems confronting each program, and identifying technical assistance needs. During FY94 AIDSCAP conducted program reviews in Brazil, Haiti, Jamaica, and Senegal.

AIDSCAP is developing a comprehensive dissemination strategy to expand its efforts to share information about the project experience through conference participation, publications, mailings, and other information services. In FY94 the project published three issues of its newsmagazine about HIV/AIDS prevention, *AIDScaptions*, and distributed over 20,000 copies; sent five English-language packets of current literature on AIDS prevention to 4,845 colleagues and a French-language packet to 450 readers; and responded to 200 requests for information.

AIDSCAP also participated in three major conferences during FY94 by sponsoring developing country participants, presenting results of its work through oral and poster presentations, and conducting conference workshops and roundtable discussions. The project sponsored 48 participants to the VIIIth International Conference on AIDS and STDs in Africa, three to the 3rd Latin American Congress on STDs/3rd Pan American Conference on AIDS and 35 to the Xth International Conference on AIDS in Yokohama. AIDSCAP staff and implementing agency collaborators made 40 presentations at these and other conferences describing results of AIDSCAP interventions and programs.

Although most AIDSCAP programs are designed to address specific country needs, additional programs have been developed to address problems that affect HIV/AIDS prevention worldwide. These special initiatives include AIDSCAP's partnerships with other organizations working in AIDS prevention, such as the PVO Grants Program, and an agreement to provide technical assistance in HIV/AIDS prevention to UNICEF.



AIDSCAP

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AIDSCAP's PVO Grant Program conducted its final round of competition in FY94 and awarded grants to PLAN International for a project in India and MAP International for an intervention in Kenya. A total of 10 grants have been awarded to PVOs through this competitive mechanism; all of the projects have been incorporated into AIDSCAP country programs.

Initiatives begun during FY94 in response to the changing epidemic include a small grants program to support demonstration projects in AIDS care and management, a pilot program to test the efficacy of providing rapid-response funding for care and management in selected countries, and a Women's Initiative to maximize the impact of AIDS prevention programs on women in developing countries.

These special programs and other AIDSCAP activities are described in more detail in this report, which is the project's first annual report since its conversion from a cooperative agreement to a contract. Annual reports will replace the semiannual reports that were produced during the first two years of the project.



AIDSCAP DESIGN AND IMPLEMENTATION

		FY 1992	FY 1993	FY 1994	FY 1995*	FY 1996*
A F R I C A	Cameroon		\$ SIP			
	Ethiopia	SP	\$ IP			
	Kenya		\$	SIP		
	Malawi	SP	\$ IP			
	Nigeria	SIP	\$			
	Rwanda		SP	IP	\$	
	Senegal	SP	IP		\$	
	Tanzania	\$	SP		IP	
	Zambia	\$				
A S I A	Thailand	SP	IP			
	India	\$	SP			
	Indonesia			SP	IP	
L A T I N A M E R I C A	Brazil	SP	\$ IP			
	Dominican Republic		\$	SIP		
	Haiti	\$	SIP			
	Honduras			SP	IP	
	Jamaica	SP	\$	IP		

SIP = Strategic and Implementation Plan

*Projected Activity for FY95 and FY96

SP = Strategic Planning IP = Implementation Plan

\$ = Initial Mission Funds Transferred to AIDSCAP

 Transitional Program or Minimal TA

 Interruption

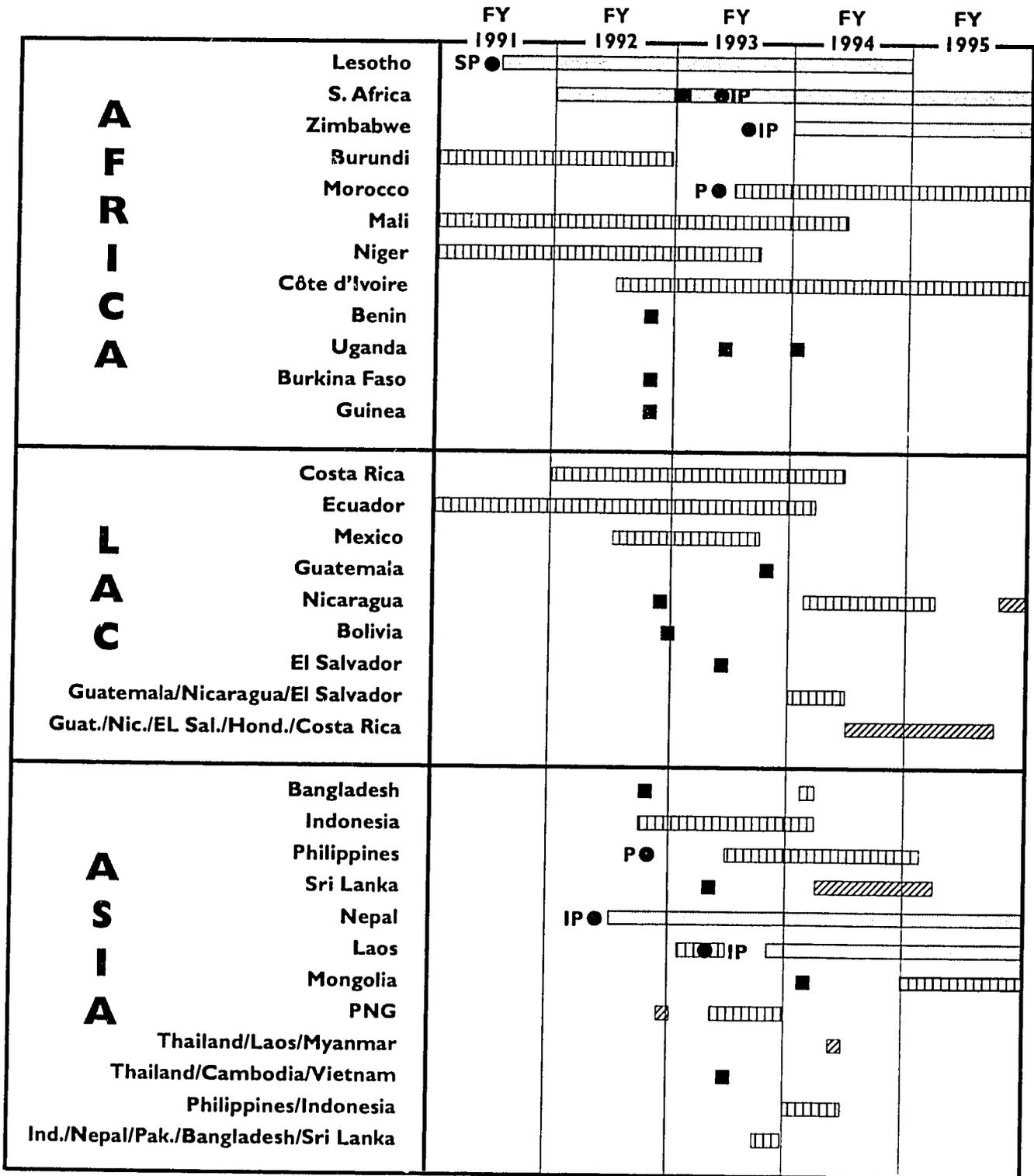
 Program Implementation

 Anticipated Implementation



DESIGN AND IMPLEMENTATION-ASSOCIATE COUNTRIES

10



▤ Anticip. Impl. ■ Short-Term TA ▤ >3 Subprojects ▤ <3 Subprojects



AIDSCAP

SUMMARY

OF

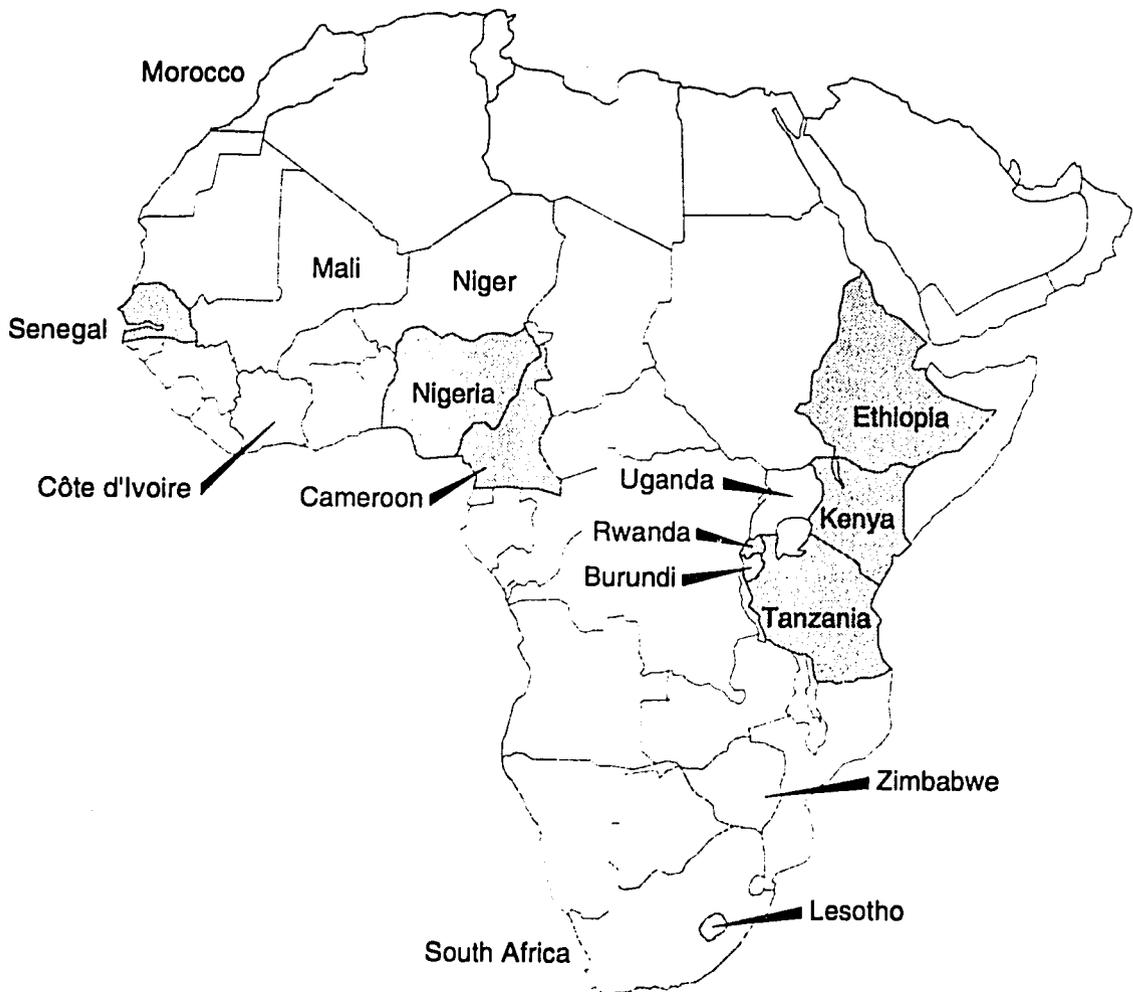
COUNTRY

ACCOMPLISHMENTS



AIDSCAP

-  Priority Country
-  Associate Country





AFRICA REGIONAL OVERVIEW

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In sub-Saharan Africa the epidemiological and socioeconomic projections of a decade ago are fast turning into reality: absenteeism from productive work due to illness or attending frequent funerals has increased; professionals trained at high cost to companies, communities, and nations die prematurely before investment in their training can be recouped; and growing numbers of children are being orphaned by the AIDS epidemic. In east, central, and southern Africa, HIV/AIDS is taking an enormous toll on families, communities, and nations.

Recent statistical information reveals disturbing trends. For example, more new infections seem to be occurring in young people aged 15 to 24, compared to the early years of the epidemic when older age groups had higher rates of infection. Infection rates among women — particularly young girls — are increasing at a faster rate than among their male counterparts. The “window of opportunity” many countries had hoped for — educating and trying to change the behavior of young people before they started their sexual lives — seems to be closing. Africa is a continent in dire need, but fortunately one also of increasingly impressive responses to the AIDS epidemic.

Seven of AIDSCAP’s 12 active priority countries are in Africa. The region also has a large associate country program. A total of 12 additional countries have received technical assistance and support; seven of these countries have ongoing efforts. A total of 45 subprojects are underway, 24 subprojects are completed, and 35 new subprojects are being designed.

AIDSCAP’s Africa portfolio is composed of countries with mature AIDSCAP programs launched in the earliest days of the project, such as Cameroon, and countries that began with more modest efforts while AIDSCAP assisted the USAID Missions in developing full-scale programs, the so-called “transitional” programs, such as Kenya and Tanzania. Some countries with programs designed early in AIDSCAP’s life have faced a host of complex implementation obstacles including debilitating political unrest, as in Rwanda and Nigeria, internal USAID contractual issues, as in Senegal, and severe downsizing and restructuring of host-country counterpart institutions, as in Ethiopia. AIDSCAP assistance to associate countries in the region range from single or intermittent technical assistance visits to programs in two countries, South Africa and Zimbabwe, with designs and budgets comparable to priority country programs.

The mainstay of AIDS prevention efforts in Africa consists of community-based programs in which peers or community representatives teach their friends, colleagues, workmates, and neighbors how to prevent HIV infection or further transmission through education, skills-building, treatment of STDs, and the use of condoms. These efforts in communities across the continent require long-term commitment and nurturing to succeed but represent the best hope for achieving and sustaining behavior change.

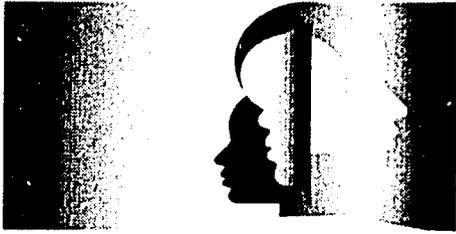


AIDSCAP

Africa continues to be the site of some of the world's most innovative AIDS prevention efforts, including testing the viability of selling pre-packaged STD treatment and prevention kits in pharmacies and exploring non-clinical risk assessment guidelines for detecting STDs in women. Africa also continues to inspire the most creative uses of condom social marketing — whether through the use of sex workers as salespersons or young men who work as entrepreneurial “bicycle agents” and are the primary distributors of condoms to retailers in Addis Ababa.

The relocation of the Africa Regional Office from Arlington to Nairobi at the end of FY93 brought AIDSCAP as a whole much closer to its field programs. The official opening of the Nairobi office was attended by USAID staff from Washington, the American ambassador to Kenya as well as ambassadors from other African countries in which AIDSCAP is operating, USAID staff based in Nairobi, and other members of the donor community. Speaking as the guest of honor, the Honorable Minister of Health for Kenya Mr. Joshua Angatia said: “I would like to assure Family Health International of the Kenya Government’s support...We pledge this support because we recognize that AIDS threatens to destroy the very foundation of our nation by afflicting our youth on whose labor, skills, and future leadership our country depends.” His words are frequently being echoed by leaders in countries across the continent.

The aggregate of these numerous efforts is a continent alive with AIDS prevention activity, which is supported financially by USAID and technically through USAID’s AIDSCAP Project.



AIDSCAP

PRIORITY

COUNTRIES

IN

AFRICA



CAMEROON

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Cameroon is a country of about 475,000 square kilometers situated on the west coast of Africa. It has a total population of 12.8 million, with a crude death rate of 12/1000 and an infant mortality rate of 63/1000. The life expectancy at birth is 53.8 years and the literacy rate for the adult population is 58 percent (males 70 percent, females 50 percent).

As of November 1993, a total of 3,067 cumulative AIDS cases were officially reported by the Ministry of Public Health (MOH). Based on sentinel surveillance data and serosurveys among high risk groups, the HIV seroprevalence was 3 percent, 6.2 percent, 26.6 percent, and 45.3 percent respectively in the general population, military, commercial sex workers (CSWs) in Yaoundé, and CSWs in Douala. Syphilis seroprevalence in antenatal clinic attenders ranges from 7 to 23 percent depending on the clinic site: 8 percent in Douala, 8.5 percent in Bamenda, 7.3 percent in Garoua, and 23 percent in Limbé.

In November 1992, an AIDSCAP team visited Cameroon to design an HIV/AIDS prevention and control project to address the several unmet needs in AIDS prevention activities. Because of the activities of the German Office of Cooperation (GTZ) in the North-West, South-West and Littoral provinces—focusing mostly on primary health care, essential drugs and HIV prevention—AIDSCAP decided to target the seven remaining provinces.

The AIDSCAP-supported program focus is on behavior change communication (BCC), STD case management, and nationwide condom social marketing. In addition, the AIDSCAP program supports the national sentinel surveillance program in collaboration with GTZ and the WHO. The primary target groups for prevention activities in Cameroon are: CSWs and their clients; STD patients; military and police personnel; youth in and out of school; and truck drivers and migrant workers.

To meet its goal, AIDSCAP is collaborating with the Government of Cameroon, including the Ministry of Public Health, the Ministry of Higher Education, and the Ministry of Defense, and international organizations and NGOs such as WHO and GTZ, Population Services International (PSI), CARE International, and Save the Children.

The AIDSCAP/Cameroon BCC strategy includes peer health education, community-based outreach programs, the development and distribution of education materials, and alternative media such as theater. The BCC strategy is complemented and reinforced by condom social marketing and improved STD services.

Major achievements during the past year include:

- Collaborating with the Ministry of Public Health and GTZ for elaboration of national STD treatment guidelines
- Completing and evaluating a pilot study on pre-packaged urethritis treatment (MST) to improve access to STD treatment



- Pretesting of STD diagnosis and treatment algorithms
- Reaching condom sales of one million per month in April
- Developing a training of trainers manual for STD/HIV prevention
- Developing a peer educator manual for commercial sex workers.

Community- and clinic-based educational activities targeted at commercial sex workers (CSWs), their clients, and STD patients were expanded to include two more sites. Sex workers were trained/retrained as peer health educators (PHEs), sharing information on STDs and HIV/AIDS, correct condom use, and health-seeking behavior with other sex workers in settings such as hotels, bars, and "chicken houses" to encourage safer sexual behavior. In addition to organizing educational sessions in their communities, the 144 active PHEs held educational sessions in STD clinics and neighborhoods, sold condoms to peers and their clients, and distributed educational materials in the six cities now covered by the program.

Other populations targeted by AIDS CAP because they engage in high-risk behavior are military and police personnel. Seven of ten garrisons are now recipients of interventions promoting safer sexual practices and improving access and availability of condoms.

The Cameroon program also targets students at the major higher education institutions in Cameroon. Education sessions were conducted at four campuses (Yaoundé I, Yaoundé II, Douala and Buea) in three cities of Cameroon by trained student peer educators. This project collaborates with the Population Services International (PSI) Condom Social Marketing Program (CSM) to establish and expand condom distribution outlets on and around all four campuses. In order to improve health care services at university health centers, 15 health personnel were trained in HIV prevention and standard treatment guidelines for urethritis in Douala and Yaoundé. In addition to this work with university students, AIDS CAP is supporting CARE/Cameroon in the implementation of a three-year project to encourage through behavior change strategies in- and out-of-school youth in the Eastern Province of Cameroon to adopt low-risk behavior.

To expand the geographic coverage of HIV prevention activities in Cameroon, AIDS CAP is supporting Save the Children to promote behavioral change among truck drivers, rural and urban migrants, CSWs, and military personnel in the Far North Province of Cameroon through a community-based AIDS education program. Project activities, delayed due to the uncertainty of funding and the impending closure of the USAID Mission, have resumed.

Two national activities are integral parts of the AIDS CAP program in Cameroon. One is the condom social marketing project implemented by Population Services International, which uses CSWs to serve as condom sales agents in non-traditional venues while CSM sales staff supply other more traditional commercial outlets. Cameroon was the first site to implement this innovative approach to condom



distribution. PSI has at least one representative in each of the 10 provincial capitals, and condom sales surpassed the 1 million per month mark in April 1994.

The other national component within the AIDSCAP program is support of Cameroon's sentinel surveillance program, which measures changes in HIV and syphilis prevalence in pregnant women in Douala, Garoua, Yaoundé, Bertoua, Limbé and Bamenda. This is a joint undertaking between the National AIDS Control Unit (ULS), GTZ, the World Health Organization (WHO), and AIDSCAP. The long-standing nature of this surveillance program and its coordination with AIDSCAP program implementation will provide AIDSCAP with a rare opportunity to assess the effectiveness of its program with more than behavioral indicators.

In the remaining two years, the AIDSCAP program will focus on:

- Expanding the university PHE program to all universities in Cameroon
- Expanding the Cameroon Armed Forces AIDS prevention program to all 10 garrisons in the country
- Conducting a study on the sensitivity of *Neisseria gonorrhoeae* to 10 commonly used antibiotics in Cameroon in collaboration with the Centre Pasteur of Cameroon
- Training health care providers in the use of STD algorithms
- Implementing AIDS care and management and women and AIDS initiatives with local NGOs
- Finalizing the training of trainers curriculum for STDs/HIV
- Finalizing peer educator manuals for CSWs, students, and military personnel.



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Cameroon Process Indicator Data

Total People Educated	132,952
Males	68,356
Females	55,314
No Gender Specified	9,282
Total People Trained	7,742
Males	2,025
Females	2,964
No Gender Specified	2,753
Total Condoms Distributed	11,757,850
Free	72,725
Sold	11,685,125
Media Spots Aired	90
Total Materials Distributed	167,912

Cameroon process indicator data in this table reflects activity through June 1994 for PSI sales data and through August 1994 for other projects, except for the following missing reports: 21471 September 1993 - August 1994; 23481 April - June 1994; 26065 June - November 1993, April - May 1994.



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Cameroon Baseline Indicators⁽¹⁾

	High Risk		Low Risk ⁽²⁾	
	Males	Females	Males	Females
HIV prevalence	6.2	26-45	3	4.2
Syphilis prevalence	5	24-34	N/A	7-23
Knowledge of 2 preventive methods	50-63	N/D	50-75	50-75
Condom use in high-risk situations	N/D	10-22	27-60	24-60
2 or more sexual partners in last 3 months	71	N/A	52	15
Youth reporting delay of sexual debut and/or subsequent abstinence			52	58

Data expressed in percentages; ranges reflect multiple populations N/A = Not applicable

N/D = Not available at time of report

(1) = Collected before or during initial stages of implementation of AIDSCAP program

(2) = Includes "youth/adolescent" populations



ETHIOPIA

Ethiopia is the tenth largest country in Africa. It has a total population of over 50 million, half of which are under 20 years of age. Over 90 percent of the population earn their living from the land, mainly from subsistence farming.

The country has a crude birth rate of 47.3/1000, a crude death rate of 19/1000, an infant mortality rate of 122/1000, GNP of USD 113, and life expectancy of 48.25 for females and 46.25 for males. As of May 1994, 12,771 AIDS cases had been reported to the Ministry of Health (MOH) from 48 hospitals in the country. Although seroprevalence surveys have not been conducted since 1990 in urban areas, when the HIV prevalence among multiple partner sexual contract (MPSC) females was about 17 percent, surveys conducted among the rural population in 1994 indicate an average prevalence rate of 2.32 percent.

In September 1992 USAID/Ethiopia signed the Support to AIDS Control (STAC-I) Project with the Government of Ethiopia. The main purpose of the STAC-I project is to strengthen the ability of Ethiopia's National AIDS Control Programme (NACP), Addis Ababa University (AAU), and other government and nongovernmental organizations to design and implement programs that reduce sexually transmitted diseases, increase condom use, and reduce high-risk behavior. The prevention programs target populations at high risk of acquiring HIV, including youth in and out of school and men and women with multiple partner sexual contacts through activities on STDs, information, education, and communication (IEC), condom promotion (primarily condom social marketing via Population Services International [PSI]), NGO support, surveillance, and behavioral research. In September 1993 the Mission amended the STAC-I document to include new outputs. There were no major alterations to the strategic approach.

The AIDSCAP program was launched in January 1993. Initial activities centered on hiring an Ethiopian resident advisor and developing of a one-year implementation plan (which was rescheduled as of January 1994). Nine subprojects have been developed since and awarded funding. The major subproject was with the MOH and focused on upgrading STD services and behavior change for the reduction of STDs/HIV transmission among MPSC persons in selected sites. Ten sites were identified for both activities in the first phase and another ten for the second phase of the project. However, due to practical issues, the sites for intensive, integrated STD and IEC programming for MPSCs and youth were reduced to four focus sites, while the remaining sixteen will only receive STD equipment and supplies and service upgrading. The first ten sites have been provided with funds for refurbishment and with STD drugs and equipment, and STD activities have started.

AIDSCAP has also begun a project to conduct a rapid ethnographic assessment of community perceptions and behaviors regarding STDs using the targeted intervention research (TIR) methodology, designed a detailed implementation plan for STD surveillance in pilot sites with statisticians from the AIDS/STD unit of MOH, sponsored an MOH statistician to attend the CDC-sponsored "International Course in Surveillance and Applied Epidemiology for HIV and AIDS," and conducted an assessment of STD lab management and its role in AIDSCAP STD case management.



The other major subagreement, with the Ministry of Education (MOE), focused on youth. Printing of 50,000 copies of an AIDS booklet in English will be completed by October 1994 for distribution to the target group of 50,000 high school students.

Population Services International's condom sales appear to be one of the most successful components of the STAC Project. Sales have been exceeding monthly targets, product recognition has been high, and new outlets have been added.

An activity that has been remarkably successful is the NGO Competitive, Non-competitive and Rapid-Response Grant Program. In May 1993 over 90 NGOs were approached directly and an open advertisement was placed in the local newspaper inviting NGOs to submit proposals for the competitive grant program. Twenty-three proposals were received; five were funded and started activities in January 1994. One NGO also has been funded through the non-competitive grants program and four through the rapid-response fund to carry out interventions targeted to out-of-school youth, those with multiple partner sexual contacts (MPSCs), ex-soldiers, farmers, and others. Subagreements with two more NGOs are under development, and proposals from another two are under review. Overall, around 41,387 people from the different target groups have been reached, most of them through the NGO program.

Capacity building through training in the planning and implementation of AIDS programs has been an important aspect of AIDSCAP's work. AIDSCAP has supported the following eight workshops:

- 1) Priority Setting for HIV/AIDS-Related Research in May 1993 for 69 participants
- 2) Effective Strategies for Behavior Change for AIDS Prevention in October 1993 for 24 participants
- 3) Materials Development Workshop in November 1993 for 34 participants
- 4) Clinical Management of STDs in February 1994 for 33 participants
- 5) Training of Trainers Workshop in March 1994 for 25 participants
- 6) Training in FHI/AIDSCAP Accounting Procedures in March 1994 for 12 participants
- 7) Evaluation Training in June 1994 for 26 participants; and
- 8) Regional Workshop on Intervention-Related Research for the Prevention of HIV/AIDS in May 1993 for 26 participants.

Additional training activities included support for 11 participants to international conferences and regional workshops on AIDS. AIDSCAP also funded the training of three staff members from the MOH at the Epidemiology Intelligence Service (EIS) course at the Centers for Disease Control and Prevention in Atlanta. AIDSCAP/Ethiopia also took an active role in World AIDS Day in 1993. During the final year of the AIDSCAP-Ethiopia project, which concludes on September 30,



1995, an integrated AIDS prevention program of improved STD services, strengthened IEC activities, and condom promotion will be fully functional in the four STD focus sites. Refurbishment will be completed, and in the second-phase ten STD clinical sites will be refurbished and provided with drugs and equipment. Training programs will be underway for personnel from all 20 STD sites on various topics geared to upgrading STD services.

Behavior change activities for MPSCs will also be activated in the four focus sites and the Addis Ababa region. Training at all levels is a major element in AIDSCAP's approach, to emphasize the importance of the MPSC program. There will be initial training of core trainers (nurses and sanitarians) who will train community health agents, group leaders, and AIDS communicators at worksites. Subsequent seminars for factory managers, government officials, bar owners, and other key people in each site also will take place to build institutional and community support.

The program will continue its focus on capacity building. Both the IEC activities in the focus sites and the reporting system of the STD clinics and the regional health bureaus will be strengthened through training and the provision of audiovisual equipment and computers.

IEC activities will continue pretesting and development by MOH and MOE of the prototype materials designed during the material development workshop for use by group leaders, community health workers, AIDS communicators, anti-AIDS clubs, and others as appropriate. The in-school youth program with the MOE will distribute AIDS booklets to students and audiovisual equipment drawing accessories to anti-AIDS clubs. Training will be provided to school staff to strengthen the in-school IEC program. Additionally, an AIDS drama videotaped by one of the NGOs will be distributed to all implementing agencies.

Current NGO subprojects will continue until the end of the project. Three new subprojects will be implemented — two targeting out-of-school youth and one targeting street children. Two workshops and two lessons learned seminars will be organized as part of the institutional strengthening process.

One of the most important successes of the AIDSCAP/Ethiopia program has been its ability to build a harmonious working relationship between government and non-government sectors. An AIDSCAP/Ethiopia forum was created in which all implementing agencies (both government and NGOs) meet biannually with AIDSCAP technical staff. In the four focus sites a parallel focus site intervention team has been set up consisting of representatives from the regional/zonal, health and education bureaus, NGOs, PSI, factory, health center, and municipality.

Another vital component of AIDSCAP's work in Ethiopia is the NGO program. This is an ideal means of reaching the hard-to-reach and vulnerable groups of Ethiopian society, particularly given the previous experience of NGOs in Ethiopia in relief and development work at the grassroots level. The AIDSCAP Ethiopia program fosters integrated activities and strong partnerships between implementing agencies as important elements in AIDS prevention. The emphasis on youth,



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both in and out of school, is also a key component as youth are a highly vulnerable group due to their age and exposure to high-risk activities.

In summary, the AIDSCAP program in Ethiopia is well underway. Since January 1993, AIDSCAP has focused efforts on four focus sites—Nazareth, Awassa, Mekele, and Bahir Dar—where refurbishment has been completed and equipment and clinical training provided. A total of nine subagreements have been awarded for STD prevention, surveillance, IEC expansion, and condom social marketing. Five were awarded under a very successful competitive grants program. Over the next year an integrated AIDS prevention program of improved STD services, strengthened IEC activities, and condom promotion will be fully functional at the focus sites. An additional 16 other STD clinic sites will be provided with better equipment, improved facilities and, in some cases, with clinical training.

Ethiopia Process Indicator Data

Total People Educated	50,673
Males	18,909
Females	24,709
No Gender Specified	7,055
Total People Trained	2,990
Males	1,355
Females	1,448
No Gender Specified	187
Total Condoms Distributed	21,887,347
Free	5,252
Sold	21,882,095
Media Spots Aired	1,283
Total Materials Distributed	55,326

Ethiopia process indicator data in this table reflects activity through August 1994 for most projects except for the following missing PIFs: 23489 October 1993 - June 1994; 23487 April 1993 - August 1994. PSI condom sales figures were used for months when PIFs were not submitted for the condom social marketing project.



Ethiopia Baseline Indicators⁽¹⁾

	High Risk		Low Risk ⁽²⁾
	Males	Females	
HIV prevalence	N/D	N/D	16
Syphilis prevalence	N/D	N/D	9
Self-reported STD prevalence	N/D	N/D	4-7 ⁽²⁾
Knowledge of 2 preventive methods	N/D	N/D	88-89
Knowledge of asymptomatic transmission	N/D	69	40
Condom use in high risk situations	N/D	45-48	37-59
2 or more sexual partners in last year	N/D	N/A	10-17

Data expressed in percentages; ranges reflect multiple populations

N/A = Not applicable

N/D = Not available at time of report

(1) = Collected before or during initial stages of implementation of AIDSCAP program

(2) = Data not currently disaggregated by gender



KENYA

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Kenya, an East African country bordering the Indian Ocean, has a population of 27 million, with a natural increase of 3.3 percent per year. The crude birth rate is estimated to be 44/1000, the crude death rate is 10/1000, and the infant mortality rate is 66/1000. The Kenyan economy is dependant on agriculture, which accounts for 25 percent of the gross domestic product. The annual per capita income is estimated to be USD 330.

The Ministry of Health's National AIDS Control Program (NACP) reported 49,879 AIDS cases from 1985 through June 1994 (Kenya National AIDS Control Program, NACP, 1994). Currently over 760,000 people are estimated to be infected with HIV, approximately 730,000 adults and 30,000 children. Based on urban national sentinel surveillance data, the NACP estimates HIV prevalence among adults at 5.7 percent, with a range of 11-12 percent in urban areas to 4-5 percent in rural areas. During the transitional period between AIDSTECH and AIDSCAP and prior to receiving priority country status, Kenya was an AIDSCAP associate country with a limited amount of funding available for four subprojects, which have now been expanded to fit within the larger program strategy. The AIDSCAP Kenya strategic/implementation plan, which was approved in early 1994, is designed to address the epidemiologic trends of HIV/AIDS in the country and to complement ongoing efforts by other donors and the PVO/NGO community and the strategic focus of the overall USAID program.

NATIONAL LEVEL

In the nine months since the launch of the priority country program, AIDSCAP Kenya has been implementing a comprehensive, integrated, and targeted program with both national and geographically focused interventions. The national interventions include promotion of policy dialogue, support for mass media, and activities in capacity building and sustainability. Because the national-level interventions provide a supportive framework for intensive prevention activities within targeted geographical areas, priority has been given to development of these national initiatives and the following have been accomplished:

- Preparation of "A Review of Policy Dimensions of HIV/AIDS in Kenya" to suggest how best to support governmental and nongovernmental sectors to identify, analyze, and promote AIDS prevention activities
- Provision of technical assistance to initiate an analysis of household, sectoral, and macroeconomic data to produce a socioeconomic impact publication
- Support to the NACP to initiate monitoring of sentinel surveillance in six rural sites (data previously collected only in urban sites)
- Continued assistance to upgrade the project tracking and sentinel surveillance computerized systems at the NACP.



Additional accomplishments on a national scale include the following:

Weekly Radio Shows:

Radio shows are broadcast in five different languages to provide information on STD/HIV/AIDS, correct information and myths, and expose disabling attitudes and practices that compromise the ability to change behavior. A feedback network through award-giving contests with program listeners assesses the transmission of messages from the shows.

AIDSWATCH:

A newspaper column is published weekly in the Sunday magazine section of a national newspaper, which provides a national forum for experts to respond to issues and concerns as they arise, publicly through the column and personally by letter.

Miujiza Theater Project:

AIDs information and model interventions for behavior change are delivered through professional theater performances that include audience participation and video productions. Three one-act plays were performed in theaters, worksites, schools, and community centers, and two videos were produced this year. A second project has been developed that extends performances to Eldoret and Mombasa.

Strengthening a National NGO AIDS Consortium:

Technical assistance is provided to guide 28 of the members through a materials development process to: 1) reinforce and strengthen collaboration and 2) assess education and communication needs and develop materials.

Resource Center for the National NGO AIDS Consortium:

A center is being established that will act as a central point where members will be able to access information through a core set of journals, books, videos, an AIDS database, and the AIDSCAP/NACP project tracking system. Additionally a system for developing educational packages for distribution to NGOs and governmental organizations at the district level is being initiated.

AIDSCAP has also established linkages with the Overseas Development Agency for potential support of a cost-recovery system for pre-packaged STD drugs, participated in advisory group meeting to revise national STD algorithms, and planned validity testing of vaginal discharge algorithms and field testing of STD training materials.



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**GEOGRAPHICALLY
FOCUSED
ACTIVITIES**

In the geographically focused areas, the target populations are men and women in the workplace, men and women seeking STD services at clinics, men and women seeking services through maternal child health/family planning programs, and students attending institutions of higher learning in the urban and peri-urban areas of Nairobi, Mombasa, and Eldoret. These target groups were selected for several reasons: (1) their potential as links between the current and future epidemic; (2) the advantages of building on the existing infrastructure; and (3) the need to complement existing efforts focused on core risk groups.

The following has been accomplished in geographically focused areas:

- Technical assistance has been provided to design workplace peer education and STD interventions in Nairobi, Mombasa, and Eldoret;
- Peer education programs have been initiated in Nairobi, Mombasa, and Eldoret. Three seminars for 49 managers from 27 companies have been conducted and 80 peer educators from eight companies have been trained.

SUBPROJECTS

AIDS Education Curricula for Family Planning (FP) Providers:

Through existing family planning delivery networks in the private sector and through clinic and community-based programs, AIDS education and condom promotion are being integrated into the standard curricula for family planning providers by the Family Planning Private Sector Project (FPPS) in collaboration with the Ministry of Health.

Training in STD Case Management for FP Providers:

This project complements the above project by developing/adapting an STD case management curriculum, which is being added to the existing HIV/AIDS counseling curriculum and family planning method update to produce a five-day comprehensive refresher course for family planning workers.

HIV/AIDS Education in Institutions of Higher Learning:

Students in ten of Kenya's institutions of higher learning are being targeted through peer education at an institutional level and through a newsletter, resource center, and annual conference and awards program at a central level.

The programs described above are complemented by the award of a PVO/NGO grant to MAP International to foster integrated action against AIDS with Kenyan churches and the selection of Kenya as one of the sites for both the international HIV Counseling and Testing Research Project and the Private



Sector AIDS Policy Presentation (PSAPP) Project. Additionally, operational research projects are planned to: (1) evaluate the integration of STD diagnosis and treatment with family planning services and (2) study sexual negotiation strategies between heterosexual couples to provide positive examples for the weekly radio show and Miujiza Theater scripts.

In summary, the AIDSCAP Kenya program has succeeded in initiating its national-level interventions and providing a solid framework for the geographically focused activities. This promotion of community ownership and creation of a synergistic effect between projects is a slow but critical process. AIDSCAP Kenya will continue to build on this solid framework for the remainder of the project, emphasizing collaboration between projects and the commitment of workplace and community resources to promote sustainability.

Kenya Process Indicator Data

Total People Educated	8,413
Males	9
Females	13
No Gender Specified	8,391
Total People Trained	395
Males	147
Females	246
No Gender Specified	2
Total Condoms Distributed	12,816
Free	12,816
Sold	0
Media Spots Aired	0
Total Materials Distributed	5

Kenya process indicator data in this table reflects activity through August 1994 for most projects except for the following missing reports: 23473 May - December 1993; 23490 August 1994.



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Kenya Baseline Indicators⁽¹⁾

	High Risk		Low Risk ⁽²⁾	
	Males	Females	Males	Females
Knowledge of 2 preventive methods	N/D	N/D	N/D	78-94
Condom use in high-risk situations	N/D	N/D	N/A	N/A
STD treatment according to national guidelines	<10	<10	<10	<10
2 or more sexual partners in last year	N/D	N/D	N/A	N/A

Data expressed in percentages; ranges reflect multiple populations

N/A = Not applicable

N/D = Not available at time of report

(1) = Collected before or during initial stages of implementation of AIDSCAP program

(2) = Includes "youth/adolescent" populations



NIGERIA

Nigeria has an estimated population of 96.7 million people, with an officially reported 1,128 AIDS cases as of May 31, 1994, and an estimated HIV prevalence of 1.2 percent. The sexually active age group, 15-44 years, constitutes over 60 percent of the total population. The crude death rate is 14/1000 while the life expectancy at birth is 51 years.

The AIDSCAP/Nigeria program was designed in May 1992 in response to the Government of Nigeria's call to the international donor agencies for support in its efforts to combat the AIDS scourge.

Some donors such as WHO/GPA assisted the National AIDS/STD control program (NASCP) in policy development, infrastructure planning, and provision of technical assistance in epidemiology, IEC implementation, blood screening, program management, and logistics. The British High Commission supplied blood screening and STD reagents and equipment for 46 federal and state hospitals in the country; the European Economic Community (EEC) worked to improve STD services; Africare assisted in AIDS education among health workers and decision makers in health; while other organizations such as the UNFPA, the World Bank, and UNICEF also assisted in other areas.

The AIDSCAP Program is focused in three states—Lagos, Cross River, and Jigawa— with particular emphasis on the following target groups: commercial sex workers, long-distance drivers, post-secondary school students, and male workers in urban areas. AIDSCAP's strategy focuses primarily on communication to bring about behavior change, ensuring accessibility to STD services, and condom promotion and accessibility. Other organizations that collaborate in the project are: Africare for NGO capacity building, Population Services International for condom social marketing, and the Combatting Childhood Communicable Disease Project (CCCD) for information regarding the STD/HIV/AIDS surveillance system.

Since its inception in October 1992, the AIDSCAP program in Nigeria has established peer outreach programs to provide information and education for behavior change. The program has promoted condom use and STD treatment-seeking behavior and referral among CSWs and their clients in two locations in Cross River State. Also in that state, youths in 17 tertiary institutions are implementing the AIDSCAP strategy for prevention and control of HIV/AIDS. This strategy is being implemented in two motorparks in Jigawa State and one motor park in Cross River State. AIDSCAP has conducted a baseline assessment to define STD problems and initiated similar assessments for condoms, behavior change, policy development, behavioral research, and evaluation.

AIDSCAP has completed a project-wide assessment of the STD needs of the AIDSCAP implementing agencies, developed linkages with the European Community and MotherCare, provided STD technical assistance to the adolescent behavioral research project in Nigeria, developed algorithms for STD syndromic management, and organized STD training curricula for physicians, pharmacists, and patent medicine dealers.



AIDSCAP

Fourteen rapid-response grants were awarded to small NGOs to carry out short-term interventions on HIV/AIDS, mostly education and sensitization of the public through rallies and community mobilization. These NGOs also distributed condoms and educational materials, as well as information on provision of STD services, to specific target populations. Through Africare, five training workshops on HIV/AIDS education, IEC, counseling, and management were held for 69 participants from 38 NGOs. Two seed grants were awarded.

The Society for Family Health (SFH), a local affiliate of PSI, sold over 30 million condoms through traditional and non-traditional outlets in more than 20 states of the country for family planning and AIDS control.

Nigeria program implementation was effectively suspended twice since project start-up in FY93. In the first instance a travel ban was issued from June through August 1993 in anticipation of national elections, which were eventually cancelled. From April through June all travel to the country was suspended due to the State Department's decertification of Nigeria, and following that due to political unrest. These delays have prevented the timely provision of technical assistance critical to effective program start-up.

During the remaining two years of the AIDSCAP Nigeria program, other activities, such as workplace interventions, policy development, and production of a video to support workplace interventions, will be implemented. The ongoing programs will be strengthened and selected health workers from the three target states will receive training on appropriate means of diagnosing and treating STDs. The SFH/PSI innovative approach to condom social marketing will be field tested and implemented.

Africare will conclude NGO capacity-building training workshops and award of seed grants and conduct follow-up training for the NGOs that had participated in earlier training workshops.

In summary, the AIDSCAP Nigeria program, despite several shortcomings occasioned by the country's sociopolitical instability, has succeeded in playing a leading role in HIV/AIDS prevention in selected states through NGO implementing agencies and individuals. The use of peer educators and outreach workers in some of the subprojects is a major strength of the program, while the Calabar CSW subproject and the Cross River Youth subproject have been very successful and may be replicated in other parts of the country.



Nigeria Process Indicator Data

Total People Educated	21,289
Males	4,592
Females	4,137
No Gender Specified	12,560
<hr/>	
Total People Trained	321
Males	68
Females	105
No Gender Specified	148
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Total Condoms Distributed	357,478
Free	79,396
Sold	278,082
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Media Spots Aired	13
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Total Materials Distributed	10,141
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Nigeria process indicator data in this table reflects activity through August 1994 for most projects except for the following missing reports: 23468 April - June 1993, September 1993, August 1994; 23469 November 1992 - January 1993, March 1993 - July 1994; 23483 August - September 1993, August 1994; 33468 June - August 1994; 33469 February - May 1994, July 1994.



Nigeria Baseline Indicators⁽¹⁾

	High Risk		Low Risk ⁽²⁾	
	Males	Females	Males	Females
Knowledge of 2 preventive methods	N/D	N/D	24-60	24-60
Appropriate perception of risk	N/A	N/A	N/D	N/D
Condom use in high-risk situations	4	23	10-50	34-50
STD treatment according to national guidelines	<10	<10	<10	<10
2 or more sexual partners in last 3 months	33	N/A	N/D	N/D

Data expressed in percentages; ranges reflect multiple populations

N/A = Not applicable

N/D = Not available at time of report

(1) = Collected before or during initial stages of implementation of AIDSCAP program

(2) = Includes "youth/adolescent" populations



AIDSCAP

RWANDA

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Rwanda, a landlocked country of little more than 10,000 square miles in the lake region of eastern central Africa, is among the most densely populated countries on the continent. With a population of over 7 million and a growth rate in 1989 of 3.8 percent, it has an annual per capita income under USD 300. Life expectancy fluctuates around 50 years and infant mortality has been 110/1000. Half the adult population is literate. In 1992 HIV seroprevalence was estimated to be about 30 percent in the capital of Kigali, at least 10 percent in large towns, and approximately 2 percent in the rural areas, where 85-90 percent of the population lived. Civil war plagued the country intermittently from 1990 until mid-1993, when peace accords were signed between the warring factions. In April 1994, however, the assassination of the Rwandan president precipitated three months of intense warfare and ethnic killings. An estimated half million Rwandans died, 2 million fled to neighboring countries, and large segments of the remaining population were internally displaced. Relative stability has returned only recently to Rwanda with the July 1994 military victory of the Rwandan Patriotic Front.

Following the events of April 1994 in Rwanda, US Embassy and USAID Mission operations were suspended. AIDSCAP Rwanda expatriate staff were evacuated to a Nairobi safe haven on April 9 and currently are monitoring events from the AIDSCAP Regional Office in Nairobi.

Until conditions permit a resumption of activities inside Rwanda, AIDSCAP activities are limited to HIV/STD prevention in the Rwandan refugee camps in northwestern Tanzania.

**AIDSCAP
RWANDA
PROGRAM
ACTIVITIES:**

Two subprojects were active by April 1994. AIDSCAP/Rwanda had a task order with Population Services International (PSI) for a nationwide condom social marketing program, which was operational for more than a year and was exceeding expectations at the time of the evacuation. With AIDSCAP funding, PSI was expanding its social marketing operations to all urban centers and had carried out a number of promotional events. CARE International had initiated activities for the Eastern Rwanda AIDS Prevention Project (ERAPP), had completed most of the groundwork, and was to have begun training health care workers in late April.

Other subprojects were in the final planning stages. Subprojects with the Centre d'Information, Documentation, et Communication (CIDC) and the Region Sanitaire de Gitarama were near approval. A subagreement for strengthening the capacity of the National AIDS Control Program (PNLS) was partially developed, dependent on political developments for completion. Collaborative activities with the PNLS were nonetheless proceeding, including a planned intervention to prevent transmission of STDs in the displaced person camps north of Kigali. Major organizational development assistance for the PNLS was planned.



Similarly, policy work, linked to a socioeconomic impact study, was scheduled for this year. Technical assistance from AIDSCAP was planned to analyze epidemiologic data and to assist in the presentation and dissemination of results.

A major intervention was planned to improve the clinical management of STDs in the city of Kigali. Support was to be provided to the Biryogo Health Center to act as a practical training site for clinicians from other Kigali health centers. Rapid-response funds were to be used to support risk-reduction work with commercial sex workers and youth.

Other STD interventions included close collaboration with the Rwanda Integrated Maternal Health Project (RIM). Adoption of national guidelines for the management of STDs was considered a prerequisite for the upgrading of STD case management. Operational research into the feasibility of syndromic diagnosis and treatment algorithms was well underway in two pilot clinics. Following the expected adoption of national algorithms and treatment guidelines, health worker training was to take place in the second half of the year.

As of April 6, 1994, work was well underway on the targeted intervention research (TIR), an ethnographic study of beliefs surrounding sexually transmitted disease. AIDSCAP's behavioral research specialist in Rwanda had constituted a technical advisory group (TAG) to supervise the field work. Other planned behavioral research included study of sexual relationships and exchange in Rwanda; life trajectories of female commercial sex workers in Rwanda; and condom use promotion among male bar patrons in Butare. This research was designed to support AIDSCAP's interventions among target groups in Rwanda. Field work would have begun by late April. A core-funded NGO grant was also in final development between AIDCAP/Washington and CARE International and ACCORD.

Following the April evacuation, AIDSCAP activities were reoriented to the Rwandan population living in refugee camps in northwestern Tanzania along Rwanda's eastern border. Through reprogramming, funds were made available to two AIDSCAP collaborating agencies, PSI and CARE International, to provide condoms and community education respectively, and to John Snow International (JSI) to conduct an initial assessment and evaluation.

Despite AIDSCAP's short tenure in Rwanda, some tangible results were realized. Over a million condoms were sold through PSI's social marketing program, which was averaging sales of over 100,000 per month by April 1994. CARE International had developed and pretested HIV/STD prevention materials that are now being adapted for use with the Rwandan refugee population. In fact, the approaches developed for use in the displaced persons camps within Rwanda are being used as a basis for interventions to control STDs, promote condoms, and encourage safer sexual practices in the refugee camps in Tanzania.

Presently, and until conditions improve within Rwanda, AIDSCAP/Rwanda interventions are focused exclusively on the refugee population in the Ngora camps in Tanzania. An assessment team visited the camps in August to work with



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a consortium of relief organizations working under the United Nations High Commission on Refugees (UNHCR) umbrella to plan a coordinated intervention. The assessment revealed an environment ripe for HIV/STD transmission with a thriving economy, an abundance of locally-brewed alcohol, and a disproportionately high number of youth and women. Condoms are not yet readily available. The neighboring town has grown exponentially as has the traffic passing through local truck stops. New bars and "hotels" sprout up overnight. Interviews revealed that moral values have broken down under conditions in the camps.

The intervention designed to combat this situation includes community peer education, condom promotion and distribution, and improved management of STDs. CARE International has recruited AIDS community educators from among the refugee population, many of whom had worked in a similar capacity in displaced person camps in Rwanda. These AIDS community educators (ACEs) will be mobilized to teach and reinforce message about AIDS prevention, condom promotion and use, and health-seeking behavior. STDs will be treated at outpatient departments at the various hospitals set up by Médecins Sans Frontières (MSF), International Rescue Committee (IRC), and other international NGOs. AIDSCAP will work with AMREF to tailor STD treatment guidelines for use in outpatient departments. Risk reduction and primary prevention education will be an essential component of this clinic-based intervention. Condoms will be available at the clinic sites. PSI/CARE will support these activities with condom procurement and distribution, both through clinics and in the community. HIV/STD prevention will be promoted in the adjoining town as well as within the refugee camps.

The AIDSCAP country program in Rwanda, though interrupted soon after the start of implementation, achieved some important results. Many of the experiences gained in Rwanda are being applied to HIV/STD prevention activities within the Rwandan refugee camps in Tanzania. Resumption of AIDSCAP activities within Rwanda will depend upon improvement of conditions within the country.



SENEGAL

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The HIV/AIDS epidemic is at an early but potentially volatile stage in Senegal. Situated on the most western coast of Africa, Senegal has a total population of 8 million, with a crude death rate of 16/1000 and an infant mortality rate of 80/1000. The life expectancy at birth is 58 years.

The number of officially declared AIDS cases was 1297 (May 1994), and HIV prevalence from sentinel surveillance data is estimated at 33.9 percent in urban CSWs (Kaolack, 1992) and 0.2 percent in pregnant women (Dakar, 1992). Syphilis seroprevalence in antenatal clinic attenders for the years 1989 to 1991 ranges from 1.4 percent to 8.4 percent, depending on the clinic. Other reported STD prevalence rates for the same years were 5 - 24 percent for *Neisseria gonorrhoeae* and 11.7 - 34.8 percent for *Chlamydia trachomatis* in prostitutes.

In 1992, an AIDSCAP implementation team designed an HIV/AIDS prevention control project that could address the unmet needs of the National AIDS Control Program (NACP). USAID was not alone in pledging support for the NACP: other major donors at that time were the World Health Organization (WHO), the Canadian International Development Agency (CIDA), the European Community (EC), and French Cooperation.

Responding to the Government of Senegal's (GOS) wish to decentralize the AIDS Control Program, the AIDSCAP project was directed toward four of the ten Senegalese regions inhabited by more than 60 percent of the total population: Dakar, Thies, Kaolack, and Ziguinchor. Major components of the national STD/AIDS control program would be supported by AIDSCAP: behavior change communication, strengthening case management of STDs, and the promotion and distribution of condoms nationwide, not just in the AIDSCAP intervention regions. While these three components were considered crucial, other components such as policy dialogue, support to the national and regional AIDS control programs in strategic planning, grant support to national and international NGOs as part of capacity building, behavioral and operations research, and evaluation, (including support for sentinel surveillance), were considered complementary and important program components to support.

Behavior change communication (BCC) would be targeted to high-risk populations, such as CSWs, other women at risk with multiple partners, and men at risk, such as men in the workplace, long-distance drivers, and the military. Youth in and out of school are targeted because of their nature as risk takers. Recent studies in Senegal have shown a precocious age of first sexual contact.

While the focus of BCC is on urban/periurban populations, more attention needs to be paid to the serious problem of internal/external migration for both men and women, and the particular risks for those spouses who stay at home and are exposed to returning infected spouses. In looking at all of the above, women are particularly disenfranchised, and the notion that only CSWs are at "high risk" is being reevaluated given new assessments. The recession, coupled with the devaluation of local currency, has further weakened the rather fragile economic fabric



supporting women. The woman at risk is also the migratory domestic looking for work, the single divorced mother with children, the co-spouse in a polygamous marriage, and the spouse exposed to the virus by a returning husband.

AIDSCAP is also forging new and strong links with national and international NGOs, using its links to the community to dovetail HIV/AIDS behavior change interventions.

In Senegal, AIDSCAP completed a detailed needs assessment of clinical sites, addressing training needs, clinic infrastructure, and drug availability. AIDSCAP formalized linkages with the European Community in Senegal to participate jointly with the Ministry of Health in the evaluation of syndromic management and gonococcal sensitivity studies, began ethnographic assessment of STD client and provider perceptions, and began procurement of drugs and test kits after obtaining the necessary approval waivers from USAID.

At the end of the first year of the AIDSCAP project, considerable advancements have occurred in all program areas, despite major funding delays. The STD component has completed a baseline survey in all intervention regions for pilot STD sites that will be the basis for comparison at the end of the project. Targeted intervention research (TIR) focusing on the treatment-seeking practices of patients with STDs was completed in October 1994. Initial analysis of general health beliefs has shown new information that may be valuable in explaining why the population is not as concerned, as was expected, by sexually transmitted diseases. Two subagreements have been developed in the public and private sectors. By the end of the project, 80 percent of all health centers will have improved STD services.

During the first year, behavior change communication (BCC) in Senegal has been focused primarily on training health personnel, social workers, school teachers, youth organizers, and those concerned with women's issues. AIDSCAP and the NACP have trained people who will in turn be trainers and peer educators. They are now poised to start outreach to the designated populations at the start of the new fiscal year. Subprojects have been finalized targeting men in workplaces and university students. Other subagreements include BCC materials development for high-risk groups and mass media message distribution over the radio.

The condom logistics component has evaluated the previous logistics system and instituted a quarterly distribution plan for the regions. The storage areas for NACP condoms have been renovated, disinfected, electrified, secured with grills and locks, and protected from rain seepage. The new quarterly distribution system commenced in April 1994, delivering condoms to the regions for specific institutions or risk groups determined by the NACP. The majority of these groups will be oriented towards condom social marketing (CSM) once the SOMARC project is underway.

In the remaining four years of the Senegal program, the focus will be on implementing the more than ten subprojects that have been developed. At least 60 national non-health NGO AIDS facilitators will be trained annually to provide



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AIDS expertise to focus their organizations on long-term behavior change interventions. Regional policy seminars will highlight the effect of the AIDS epidemic on the individual regions to galvanize political opinion leaders to take the necessary actions to stabilize the epidemic.

In summary, the AIDSCAP Senegal program has succeeded in acting as a catalyst for governmental and nongovernmental agencies, communities and individuals in their fight against HIV. The ethnographic research study (TIR) will elicit important and previously unknown information for STD services. The study of religious and political opinion leaders was effected at an auspicious moment to strengthen political dialogue by defining a strategy to harness the considerable ability of religious leaders for social mobilization of their defined populations toward HIV prevention nationally.



TANZANIA

AIDSCAP

Tanzania, situated on the east coast of Africa, has a total population of 27 million (based on projections from the 1988 census), with a crude birth rate of 46/1000, crude death rate of 15/1000 and an infant mortality of 102/1000. The life expectancy at birth is 48 years and the annual per capita income is USD 90-100. Secondary school education is rare. Of the age group 20-24 years, 7.6 percent of females and 9.4 percent of males have completed primary school. As of October 1993, 42,226 AIDS cases had been officially reported (although the number of estimated AIDS cases is more than 120,000). HIV prevalence is currently estimated at 55.7 percent and 11.5 percent for urban high-and low-risk populations, respectively. Syphilis seroprevalence was approximately 2.8 percent in antenatal clinic attenders during 1993.

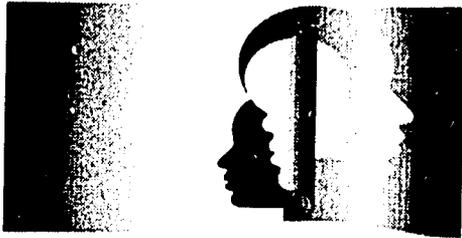
Tanzania represents one of AIDSCAP's "transitional" countries in which numerous activities launched under the predecessor AIDSTECH project were continued and expanded while the Mission designed its Tanzania AIDS Project (TAP). Model subprojects initiated by AIDSCAP and others (such as the AMREF Trucker's High Transmission Area Project) prior to the start of TAP are being replicated under TAP.

The Tanzania AIDS Project (TAP) agreement was signed in June 1993. It was designed to contribute to the NGO component of the National AIDS Control Program (NACP). (NGO within the context of the TAP is broadly defined and includes businesses, schools, and religious institutions.) The TAP operates through the nongovernmental sector to carry out AIDS prevention and control work and support orphan activities. AIDSCAP and its subcontractors were offered the opportunity to implement the TAP.

The TAP is a national \$20 million five-year project aimed at 1) reducing the social and economic impact of AIDS on Tanzanian society by reducing the HIV transmission rate; and 2) improving the socioeconomic well-being of AIDS orphans. Its purpose is to increase the practice of HIV prevention measures and ensure the provision of adequate support services to AIDS orphans and their families. NGOs in an area are encouraged to cluster their activities around a specific anchor community. In so doing, NGOs with complementary programs achieve greater impact.

The TAP collaborates with every segment of society, including government, business, religious institutions, PVOs, hospitals, and schools. Its programs are multi-dimensional; they encompass IEC/BCC, condom distribution, STD diagnosis and prevention, care and counseling, and orphan support. During its first year, the TAP staff grew from eight to thirty-three.

The target group includes sexually active adults and orphans. To reach this large audience, various media are being used to disseminate messages: large and small print media, radio, television, and musical and drama troupes. Social marketing techniques are being used not only to market condoms, but also to market the very idea of behavior change itself. The number of condoms distributed now exceeds 2,316,720. The role of peer educators in STD treatment referral has been explored at



AIDSCAP

truck stops. Work with the NACP in support of a national STD treatment algorithm for use by medical professionals continues. The TAP is also working with organizations that are providing care and counseling to persons with AIDS and their survivors.

Local and international experts have assisted the TAP in planning project components. Toward that end, a national institutional needs assessment, an ethnographic family needs assessment in eight regions, a marketing plan for condom social marketing, an IEC/BCC action plan, and an STD situational analysis have been completed.

Three cluster sites have been formally opened. Field coordinators have been placed in two of the sites: Dar es Salaam and Iringa. The coordinating role in the third site, Dodoma, is being handled by World Vision. Work on two manuals to support workplace and care and counseling activities is proceeding. Workshops to assist the MOH with condom distribution at the central level were conducted.

During the next year, the TAP will expand its activities to NGOs in at least six more cluster sites. The NGOs will be supported through a resource center, NGO database, and a newsletter. Training in financial accountability, management, and IEC/BCC materials development will take place. Mechanisms to facilitate NGO collaboration at the cluster site and national level will be developed. The IEC/BCC unit will be strengthened to provide technical backstopping for NGO interventions, and manuals to support workplace interventions and care and counseling activities will be completed and distributed.

AIDSCAP has also developed a baseline clinic assessment instrument, developed linkages with the European Community to maximize resources in-country, and designated an evaluator to assess STD prevalence and risk factors for STDs in women on truck routes.

An STD training manual and curriculum will be developed for use by trainers. A journalism workshop will be held for journalists of Swahili- and English-language newspapers to improve their skills in developing health-related articles. Logistics training workshops will be held for MOH staff in order to improve condom distribution at the regional and district levels. New products for social marketing will be evaluated. An STD treatment facility assessment, an evaluation of the need for an operational study to identify risk factors for STD in women attending family planning clinics, and an assessment of national care and counseling activities will be completed. In addition, Tanzania is one of four countries to participate in the AIDSCAP/GPA Counseling and Testing Protocol, which will be implemented through the Muhimbili College of Health Sciences.

The TAP is supporting the goals of the NACP through strong NGO support. HIV/AIDS is an issue of which Tanzanians are acutely aware. Through nongovernmental organizations, the TAP is assisting in mobilizing citizens and communities to combat the epidemic on many different fronts. Infrastructure is being built and strengthened in Tanzania in ways that go beyond the TAP's mandate. Marketing



and distribution techniques introduced through AIDSCAP/PSI will benefit the Tanzanian economy as it opens up to market forces. Strengthened NGOs will bring a whole new set of skills to Tanzanian development efforts. Home care will take the untenable burden of AIDS support off hospitals, so they can be more efficiently used for treatment. Orphan interventions will help these survivors grow into productive members of Tanzanian society.

Over the next two years, sixteen subprojects in at least six more cluster sites are expected to receive funding. In addition to cluster site projects, AIDSCAP will work with local NGOs to develop youth and women and AIDS interventions

Tanzania Process Indicator Data

Total People Educated	326,508
Males	154,628
Females	142,758
No Gender Specified	29,122
Total People Trained	11,100
Males	3,374
Females	1,352
No Gender Specified	6,374
Total Condoms Distributed	6,394,833
Free	5,994,905
Sold	399,928
Media Spots Aired	14
Total Materials Distributed	290,362

Tanzania process indicator data in this table reflects activity through March 1994 for PSI sales data and through August 1994 for most other projects.

Projects 21467 and 21465 closed in March 1994. Project 21468 closed in December 1993.



Tanzania Baseline Indicators⁽¹⁾

	High Risk		Low Risk ⁽²⁾	
	Males	Females	Males	Females
Syphilis prevalence	15-18	12-30	N/D	2.8
Knowledge of 2 preventive methods	N/D	N/D	N/D	N/D
Appropriate perception of risk	93	90	N/D	N/D
Condom use in high-risk situations	96	95	N/D	N/D
2 or more sexual partners in last year	N/D	N/D	N/A	N/A
Use of condoms with regular partners	76	69		

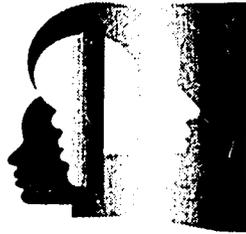
Data expressed in percentages; ranges reflect multiple populations

N/A = Not applicable

N/D = Not available at time of report

(1) = Collected before or during initial stages of implementation of AIDSCAP program

(2) = Includes "youth/adolescent" populations



AIDSCAP

ASSOCIATE

COUNTRIES

IN

AFRICA



LESOTHO

AIDSCAP

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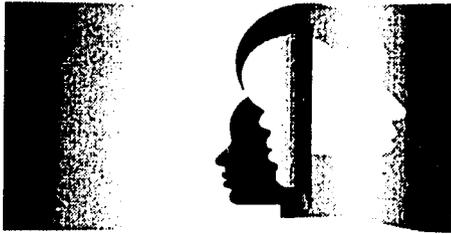
The kingdom of Lesotho, a mountainous country wholly surrounded by the Republic of South Africa, has a population of 1.8 million, growing at an annual rate of 2.6 percent. Because of its size and geographical location within South Africa, its limited resources, its high level of migrant employment in South Africa, and formal economic and ethnic ties, the country is characterized by its close links to, and dependence on, South Africa. AIDS was first reported in Lesotho in 1986, with the official number of cumulative AIDS cases reaching 348 by December 1993. The 1993 sentinel surveillance data indicate HIV prevalence to be between 12 and 21 percent among STD patients in the lowlands and between 3 and 6 percent among antenatal clinic attenders; the seroprevalence of syphilis varies between 7 and 9 percent in sites where information was available.

Sentinel surveillance data show an alarming increase in the number of teenage STD patients, who account for 9.4 percent of the total tested, as well as the high number of teenage pregnancies, accounting for 20 percent of all pregnant women. AIDS interventions and IEC messages targeting youth are critical to the control and prevention of AIDS in Lesotho.

The AIDSCAP program, initiated in early 1993, targets highly vulnerable groups through STD prevention and control, peer education, and condom promotion and distribution. The Lesotho AIDSCAP Program has succeeded in mobilizing donor support and cooperation in the development of STD treatment protocols. Improved STD treatment nationwide is expected to markedly affect the rapidly increasing STD patients. Condom promotion, education and increased access through social marketing, especially in non-clinical, rural settings, is expected to promote safer sexual practices. IEC materials development and production, supported by AIDSCAP, will increase the availability of relevant materials for both governmental and nongovernmental AIDS activities, in an effort to move the country beyond the denial phase of the epidemic. Integration of AIDSCAP activities is integral to the program: for instance, PSI is coordinating "Puppets for AIDS" performances in the communities to support ongoing CARE and Lesotho Red Cross activities.

AIDSCAP completed a needs assessment of STD/HIV/AIDS educational materials, and plans have been made to assist the Ministry of Health (MOH) and NGO staff in the development of targeted messages.

In collaboration with the World Bank, AIDSCAP is supporting syndromic treatment of STDs. An etiological study of STDs among nearly 7,000 STD clinic attenders was completed, and draft STD treatment protocols were developed. AIDSCAP is assisting in the training of all physicians and the majority of the country's nurses in the treatment of STDs using the treatment protocols. The project was instrumental in obtaining World Bank support for the STD project; the success of the project promoted further cooperation from the European Community, which has agreed to fund the additional costs of expensive STD drugs over the next two years. The STD intervention has increased the availability of STD services throughout the country.



AIDSCAP

The Red Cross and CARE programs use peer education programs targeting youth, football players, and at-risk populations in four districts. These initiatives have increased awareness of HIV/AIDS/STDs. The recently launched Lesotho Condom Social Marketing Program has already increased availability with its focus on condom promotion and distribution. In about three months, PSI provided over 28,000 condoms to distributors, predominantly in the greater Maseru area. Subsidized "Lovers Plus" condoms are being distributed to rural, non-traditional outlets to increase accessibility and affordability.

Implementation of two recently approved interventions was delayed temporarily by the political unrest: the CARE AIDS Football Project and PSI's Condom Social Marketing Project. Implementation is progressing well now that the democratically elected government has been reinstated.



SOUTH AFRICA

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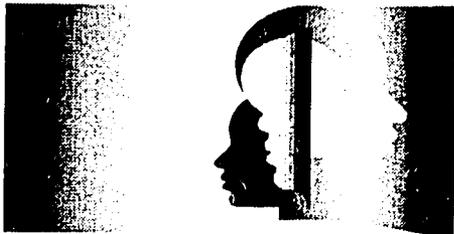
According to the Department of Health in Pretoria, the estimated population of the Republic of South Africa (RSA) is 41 million. The first case of AIDS in RSA was reported in 1982. Through January 1994, a total of 2,927 cases had been reported, with 77 percent of all reported AIDS cases in blacks and most cases associated with heterosexual transmission. Pediatric AIDS cases account for 21 percent of all AIDS cases and are almost exclusively confined to blacks. Most AIDS cases have been reported in persons from the Transvaal province, followed by Natal and the Orange Free State.

The South African response to the epidemic since 1990 has been the acknowledgement of the need to address the HIV/AIDS problem by extra-parliamentary governmental and nongovernmental organizations (NGOs). Many organizations from the national level down to the community levels have initiated or increased efforts to slow the spread of HIV/AIDS through prevention education. The formation of the National AIDS Coordinating Council of South Africa (NACOSA) in 1992 was one promising indication of the level of efforts to begin coordinating responses. But the level of activities, the kinds of approaches being taken, and the high-level commitment to long-term intervention may still be inadequate to insure sustained behavior change and to interrupt disease transmission.

Under AIDSCOM and more recently AIDSCAP auspices, the USAID/South Africa Mission has funded an office led by a resident advisor in Johannesburg since 1991 to support activities through NGOs. Highlights of this assistance have included HIV/AIDS prevention, education training for traditional healers, educational and comparative travel for NGO program implementors and health personnel, creation of an HIV/AIDS resource center in Johannesburg, and a prevention, educational, and support project in Natal for HIV-infected mothers and their families.

The USAID/South Africa Mission continues to fund AIDSCAP; in November 1993 the South African program implementation plan was finalized. The implementation plan proposes four overall strategies:

- Strengthening the capacity of community-based organizations (CBOs) and NGOs through technical training, education and comparative travel, an AIDS resource center, the traditional healers program, the Community HIV/AIDS Pilot Project (CHAMPS), and technical and financial assistance to NGOs
- Addressing the needs of CBOs through small grants
- Supporting a "model" program approach to HIV/AIDS intervention with migrant workers (miners) and their home communities;
- Supporting specific program services through government institutions, training, improved epidemiological surveillance, STD service upgrading, and condom logistics.



AIDSCAP

**EDUCATIONAL
AND
COMPARATIVE
TRAVEL**

In December 1993, AIDSCAP sponsored four South African participants to the VIIIth International Conference on AIDS and STDs in Africa; in August 1994, four South Africans were sponsored to attend the Xth International Conference on AIDS in Yokohama, Japan.

SMALL GRANTS

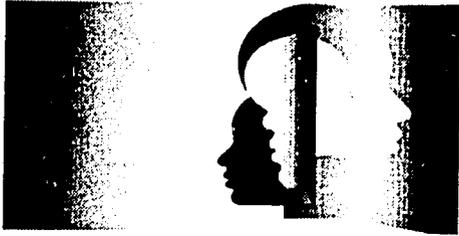
A technical working group (TWG) was constituted in April 1994 to draft qualifying criteria for subrecipients and also to select participants to take part in international conferences and inter-regional workshops. With the arrival of the AIDSCAP resident advisor and a deputy resident advisor, a full meeting of the TWG is scheduled in October 1994 to carry forward this activity.

**RESOURCE
CENTER**

In March 1994 a combined team from AIDSCAP and the Centers for Disease Control and Prevention (CDC) visited South Africa to conduct a needs assessment for this activity. A draft report was submitted to the Mission. The recommendations of the team included: decentralization of the resource center to the regions (initially four regions will be covered: Natal/Kwazulu, Transvaal, Orange Free State, and the Pretoria/Witwatersrand/Vereeniging area) and the development of culturally and linguistically appropriate IEC materials. In addition, the team developed criteria for the selection of the lead agency and networking agencies and an advisory committee. The Mission approved the report in July 1994. The next step will be the design of the resource center and the development of subagreements anticipated to occur during the first quarter of the new fiscal year.

**COMMUNITY
HIV/AIDS
PILOT PROJECT
(CHAMPS)**

This subproject, implemented by the National Association of Child Care Workers (NACCW) in Natal, continues to provide counseling and education to HIV-positive women who are heads of households, with an emphasis on reducing the number of sexual partners and encouraging correct and regular condom use. The first phase of the project ended in February 1994 and a six-month cost extension was approved. The second phase of the project was scheduled to begin on September 1, 1994; a subagreement is currently under preparation. The major thrust to the second phase will be a move from individual support toward group support and greater community involvement and establishing linkages with community self-help groups to ensure sustainability when AIDSCAP's assistance is phased out.



AIDSCAP

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Although the South African program got off to a slow start, some level of optimism can be expressed that activities will now pick up. This optimism is based on one simple factor — in recent months the RSA has undergone rapid sociopolitical changes towards democracy. The new government faces the challenging expectations of a long-disadvantaged and economically deprived majority population, including the need for equitable, adequate health care services. Unfortunately it will also face the challenges posed by the HIV/AIDS epidemic, with potentially devastating effects on health, the labor force and the economy. The RSA is equipped with resources and expertise to face this challenge, but technical assistance is greatly needed in most aspects of HIV/AIDS prevention and control.



ZIMBABWE

As of 1991, the population of Zimbabwe was nearly 11 million, with a growth rate of 3.4 percent. The prevalence of HIV/AIDS in Zimbabwe is among the highest in sub-Saharan Africa. Zimbabwe is one of the ten sub-Saharan African countries that account for 80 percent of all AIDS cases in the region. As of March 1993, 21,500 AIDS cases had been reported, up from 16,882 in September 1992.

Seroprevalence data from antenatal clinic attenders and STD patients in several rural and urban sites indicate that about 330,000 urban inhabitants and 460,000 rural inhabitants are HIV-positive. Sentinel surveillance data from 1992 indicate a range from 10 percent among rural antenatal clinic attenders to 60 percent of patients in an urban STD clinic. Overall analysis of the data indicates that HIV prevalence is high in small towns along major transport routes (30 percent), while in the five major urban areas near transport arteries, mines or military bases, prevalence is around 25 percent. Other rural areas appear to have HIV infection levels of 15 percent.

Prior to the design of the large associate country program, AIDSCAP provided financial support for a behavior change intervention with the Bulawayo City Health Services Department to reduce high-risk behavior among commercial sex workers, their clients and STD patients in Bulawayo, Zimbabwe's second largest city. AIDSCAP support for this peer education project was completed in December 1993, although the project is continuing under non-AIDSCAP support.

USAID developed the Zimbabwe AIDS Prevention and Control (ZAPAC) project, the agreement for which was signed on September 30, 1993, as the vehicle for supporting HIV-related activities. The purpose of ZAPAC is to decrease HIV-related high-risk behavior within defined target groups and strengthen the delivery services that help reduce the spread of HIV in those groups. These objectives will be accomplished through education and motivation for behavior change.

At the request of USAID/Harare, AIDSCAP sent an implementation planning team to Zimbabwe in March 1994 to prepare a proposal for AIDS prevention and control activities over the next three years (1994-1996). The proposal would be implemented as part of the Mission's ZAPAC Project. The AIDSCAP implementation plan was completed by June 30, 1994, and the Mission subsequently transferred funds for the activities to AIDSCAP.

AIDSCAP's primary focus will be on behavior change communication interventions in the workplace with occupational target groups, including the transport and commercial farming sectors, uniformed services personnel, and the families of workers in these sectors. Commercial sex workers (CSWs) in the areas of these workplace will also benefit from behavior change interventions. AIDSCAP will also devote attention to working with and through the media to disseminate accurate information on the AIDS epidemic. It will conduct a media assessment to determine the most widely used medium. AIDSCAP will train journalists in writing feature stories using scientific information, and it will train government agencies in disseminating information to the media.



AIDSCAP

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A major element of the ZAPAC project is strengthening the capacity of in-country institutions. AIDSCAP activities will therefore be implemented through selected Zimbabwean NGOs in order to strengthen their capacity in designing, implementing, monitoring, and evaluating AIDS prevention programs. In addition, AIDSCAP will undertake activities that will enhance the NGOs' skills in administration and financial management. AIDSCAP will provide technical guidance and training to the NGOs as required.

AIDSCAP's two-year program is integrated with the Medium Term Plan II of the National AIDS Control Program. It will be carried out in collaboration with other donors who are providing assistance to the NACP for the provision of condoms and to implement STD prevention and control projects. The program is still in its early stages. A resident advisor has been hired and office space identified. Recruitment of additional staff is ongoing; by the end of 1994, initial activities should be well underway.



BURUNDI

Burundi is a landlocked country in the lake region of eastern central Africa. It has population of 5.8 million (1991) and a population growth rate of 3.6 percent. The annual per capita income was USD 229 in 1991. HIV seroprevalence among pregnant women attending antenatal clinics in 1992 ranged from 1.8 percent in rural areas to 14-17 percent in selected semi-urban areas to 20 percent in the capital, Bujumbura. New workers at large factories in Bujumbura had a seroprevalence of 13 percent in 1992.

Burundi has been afflicted by civil unrest for the past decade, which culminated in the assassination of two presidents within the last year. AIDSCAP activities were suspended from October 1993 until January 31, 1994, and again from April 6, when both the Rwandan and Burundian presidents were killed, until the end of project date, May 31, 1994. Field work and data collection for the cohort of factory workers subproject was completed by September 30, 1993. The HIV surveillance study of the high-risk women cohort was suspended and ultimately canceled because of civil unrest and the evacuation of the resident consultant in April and all non-essential personnel at the USAID Mission in May 1994.

The HIV Cohort Surveillance Project with factory workers provided new knowledge about the continuing high rate of HIV infections among men in the workplace, despite the advanced stage of the AIDS epidemic in Burundi. Recent reports of stable HIV prevalence observed in prenatal women and other groups had led to the speculation that the epidemic had reached its peak. The HIV incidence rates observed in this study are higher than what was expected based on observed prevalence and should be a warning against complacency.



CÔTE D'IVOIRE

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The Côte d'Ivoire, situated on the west coast of Africa, has a total population of 14 million. AIDS was first diagnosed in Côte d'Ivoire in 1985 and HIV prevalence is currently estimated at 10 percent among the general population in Abidjan (1990 data). Syphilis prevalence among antenatal clinic attendees in Abidjan increased from 8.8 percent in 1988 to 11.7 percent in 1992.

The AIDSCAP program in Côte d'Ivoire consists of two activities: 1) the AIDSCAP policy unit is providing technical assistance to the MOH in conducting an economic impact assessment and epidemiological modeling of the AIDS epidemic; and 2) support for Africare, which is implementing a three-year project to reduce risky sexual behavior among in- and out-of-school youth ages 15 to 25 in Guiglo Department. The project, funded by the AIDSCAP competitive grant program, targets rural farmers and youth using existing community-based networks for rural development. The objectives of the policy technical assistance in Côte d'Ivoire were:

- Epidemiological modeling of the AIDS epidemic
- Training of Ivorian collaborators in modeling
- Assessing the socioeconomic impact of HIV/AIDS.

A consensus had been developed on a number of epidemiologic assumptions and some of the necessary demographic statistics. A presentation was made to USAID that summarized both the epidemiologic and economic findings. Recommendations were received for performing further analysis and for improving the presentation of the results. This activity has been in abeyance since mid-1993 as USAID/Côte d'Ivoire and USAID/REDSO sought to gain further collaboration from nationals and to receive a report on the economic data.

Africare is collaborating with the Guiglo Health Department to train a cadre of 60 community outreach health educators who will initiate HIV prevention education with out-of-school youth. Secondary school nurses will reach youth through formal presentations and informal group discussions in schools. The project will also facilitate the selection and training of a six-member HIV/AIDS advisory committee that will define health policies and strategies for the region. The project expects to reach 50,000 youth through the outreach program and 4,000 students through the school program. To date the project has accomplished the following activities:

- Finalized the formal project agreement with MOH and National AIDS Commission.
- Recruited village health educators from select villages in three of the four project prefectures. Sixty villages will participate in the project.
- Developed workshop curricula for the 60 village health educators. Held two of a series of three competency-based trainings for the VHEs.
- Developed and reviewed a draft knowledge, attitudes, and practices (KAP) questionnaire, which will be transmitted to the Africare and AIDSCAP headquarters for review.



AIDSCAP

MALI

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One of the landlocked Sahel countries of West Africa, Mali has a population close to 10 million. Since the first case of AIDS was diagnosed in 1985, more than 2000 cases have officially been reported. However, it has been estimated that actual cases may be five times this number. Nationwide, seroprevalence is 2.4 percent among men and 3.4 percent among women. For Bamako percentages are 5 percent and 55 percent, for low- and high-risk groups, respectively. In Sikasso, a border town, the rates are 5.9 percent and 71.9 percent for those same populations.

Within the framework of the Ministry of Health's National Aids Control Program, funded by a variety of donors including USAID, the World Bank, WHO, and UNICEF, the AIDSCAP Project plays a modest but crucial role. It began in September 1992, building on preceding AIDSTECH activities that were initiated in 1989.

The program targets mainly women with multiple partners (WMP) in Bamako and the districts of Segou and Sikasso with AIDS education and condom promotion and distribution. A complementary outreach program targets the clients of WMP through IEC sessions, drama presentations, and informal visits in bars and brothels. For brothel-based WMP, the project has provided systematic STD diagnosis and treatment. The project also includes the funding and training of local NGOs to run similar projects in the various districts and shanty towns of Bamako. To date, 15 NGO projects have been funded.

Although the project cannot claim to have reached the majority of WMP in Bamako through its peer educator program, it has resulted in a definite increase in the use of condoms with clients. Reported use among brothel-based WMP is close to 100 percent with clients, but usage with their boyfriends is much lower.

Finally, the 15 NGO projects under the competitive small grants program are yielding good results. The average number of people reached through these programs, which include IEC sessions, training of local youth as AIDS educators, awareness training around dances and teas, and the setting up of a commercial condom sales network (Protector condoms) is over 3000. Project staff have provided NGO training and are providing continuous technical assistance and monitoring.

During the remaining six months the project will continue most of the activities described above with the exception of peer educator training, which was completed in September 1994. Special emphasis will be given to a major activity targeting the military and to reactivating the subprojects in Segou and Sikasso. An evaluation of NGO activity will be done in November 1994 and the final report will be completed before March 31, 1995.



MOROCCO

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Morocco is a country of over 25 million people located in the northwest corner of Africa. The first AIDS case in Morocco was reported in 1986. Since then, a total of 156 cases have been officially declared to the Epidemiology Division in the Ministry of Public Health.

AIDSCAP's program in Morocco is in response to a request from the MOPH and USAID/Morocco to provide technical assistance to develop a pilot activity designed to address several key areas in STD service delivery. The activities of AIDSCAP are seen as complementary to current activities addressing family planning clients through JHPIEGO and is designed to compare the JHPIEGO Genital Tract Infections (GTI) approach to other models of STD identification and management. Additional support to certain pilot JHPIEGO GTI sites through the development and implementation of a variety of service delivery models will be provided. The AIDCAP activity represents one of the first efforts internationally to integrate services for reproductive tract infections with family planning and maternal child health services. Consequently, the model that will evolve may provide useful information not only for Morocco but internationally as well.

The major components of the AIDSCAP program are primarily equipment procurement, training in STD program skills and clinical management, technical assistance in STD etiologic agent assessment, research through an ethnographic assessment, a baseline STD services assessment, and materials development.

The first major achievement of AIDSCAP's Morocco has been to complete the project's design and finalize the project delivery order. In addition, a detailed needs assessment of clinic sites in three cities was completed and the process of procuring equipment and supplies was initiated. The project has also facilitated the training of a laboratory technician from the central reference lab and sponsored a clinician to attend the STD managers' course in Dakar.

In collaboration with the University of Washington's Center for AIDS and STDs, AIDSCAP is responding to a request from the Government of Morocco to assist in improved STD case management, which is part of a larger effort to mitigate the impact of STDs and HIV/AIDS on the health of women and children in particular. These efforts will also have a positive impact on the government's programs in primary health, family planning, and child survival. The AIDSCAP project is on its way to making an important contribution to the goals of the MOPH in Morocco.



NIGER

Niger has an estimated population of just over 8 million, with about 16 percent living in the urban areas. Data from the few HIV prevalence studies conducted in the country show a prevalence of less than 1 percent in the general population. A World Bank-funded study of HIV and STD conducted in Niamey in 1993 gave the following results: HIV infection in pregnant women: Niger nationality - 0.6 percent; other nationalities - 4.5 percent; syphilis seroprevalence was 4 percent; gonorrhea was 1.5 percent. In CSWs the HIV infection rate was 15.4 percent, gonorrhea 24.9 percent, and syphilis 26.5 percent. Since December 1992, more than 795 AIDS cases have been recorded in Niger.

The AIDSCAP-funded peer education and community outreach project in Niamey was completed on June 30, 1994. The project targeted truck drivers, STD patients, and CSWs through peer education, condom promotion and distribution, and improved STD treatment. The project was executed by the Niger Directorate of Surveillance, Epidemiology, and Prevention (DSEP), with technical assistance from AIDSCAP and funding from USAID/Niger.

Training under this project included skills improvement for project staff and training in HIV/STD communication skills and counseling techniques. In addition, DSEP laboratory technicians were trained in STD diagnostic techniques. With assistance from an AIDSCAP STD consultant, the DSEP, in concert with physicians and pharmacists from across the country, drafted STD treatment guidelines for the project. Improved STD diagnosis and treatment at the DSEP STD clinic was assured through training of clinic and laboratory staff and provision of diagnostic reagents.

The CSW component covered eight urban communities of Niamey: Koira Tegui, Banga Bana, Terminus, Gamkalle, Lacouroussou, Yantala, Nouveau-Marché, and Boukoki. Twenty-nine CSWs were trained as peer educators. Peer education sessions were conducted by the DSEP staff and peer leaders twice a month at designated brothels and meeting places. Each of the 195 sessions held included information and discussion around a chosen HIV, STD or AIDS theme, role playing, demonstration of correct use of condoms, projection of a film followed by a debate, and distribution of educational materials and condoms.

The Transport Workers Project worked with three syndicates and one transport company targeting all transport workers in greater Niamey. Education sessions were held at six sites, twice a month, at the syndicates and the transport company, including messages on transmission, prevention, and condom use. In addition, a drama on AIDS by a local theater group and films, such as "Visages du SIDA," were presented regularly in French or Hausa.

In June the project conducted the end-of-project knowledge, attitudes, behavior, practices (KABP) survey. The data has been analyzed in-country and a preliminary report in French is available. The final project report in English is currently being written by the AIDSCAP resident consultant. Preliminary results from the end-of-project KABP survey indicate that 90 percent of the CSW are using condoms with their clients and 50 percent of truck drivers, migrants, and STD patients report using a condom with their last occasional partner.



UGANDA

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Under a Mission buy-in, AIDSCAP provided technical assistance on two occasions during the fiscal year to the Islamic Medical Association of Uganda for its end-of-project behavior change measurements. The evaluation team for the IMAU's FAEPTI project (Family AIDS Education and Prevention Through Imams) conducted and analyzed four focus group discussions (FGD); redesigned, translated, and pretested the KAP survey instrument; finalized a sampling plan; wrote, translated, and pretested three FGD topic guides; planned interviewer training; and developed a work plan for the end-of-project evaluation activities (including data management, analysis, and write-up) through mid-September 1994.

Focus group and key informant interview data provide evidence of behavior change in rural areas and trading centers among Moslem families exposed to AIDS awareness information via trained Family AIDS Workers (FAWs) and imams. The survey data provide support to these qualitative conclusions, identifying statistically significant changes in knowledge of HIV transmission and prevention and condom use rates among certain segments of the surveyed sample. Multivariate analysis suggests that the trends are due to the interpersonal communication via FAWs and imams.



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**Associate Countries in Africa
Process Indicator Data**

	Côte d'Ivoire	Zimbabwe	Niger	Mali	Lesotho
Total People Educated	0	409,279	3,172	3,584	6,279
Males	0	231,805	1,108	2,151	2,315
Females	0	177,270	2,064	1,433	3,132
No Gender Specified	0	204	0	0	832
Total People Trained	68	1,306	1,168	166	117
Males	61	4	0	48	34
Females	7	73	8	76	28
No Gender Specified	0	1,229	1,160	42	55
Total Condoms Distributed	0	2,567,506	729,364	1,166,300	47,621
Free	0	2,567,506	729,364	1,166,300	47,621
Sold	0	0	0	0	0
Media Spots Aired	0	0	0	0	0
Total Material Distributed	0	81,987	930	798	2,731

Côte d'Ivoire process indicator data in this table reflects activity for April and May 1994.

Zimbabwe process indicator data reflects activity through December 1993 with the exception of August 1993. This project closed in December 1993.

Niger process indicator data reflects activity through March 1994 except for October 1993. This project closed in June 1994.

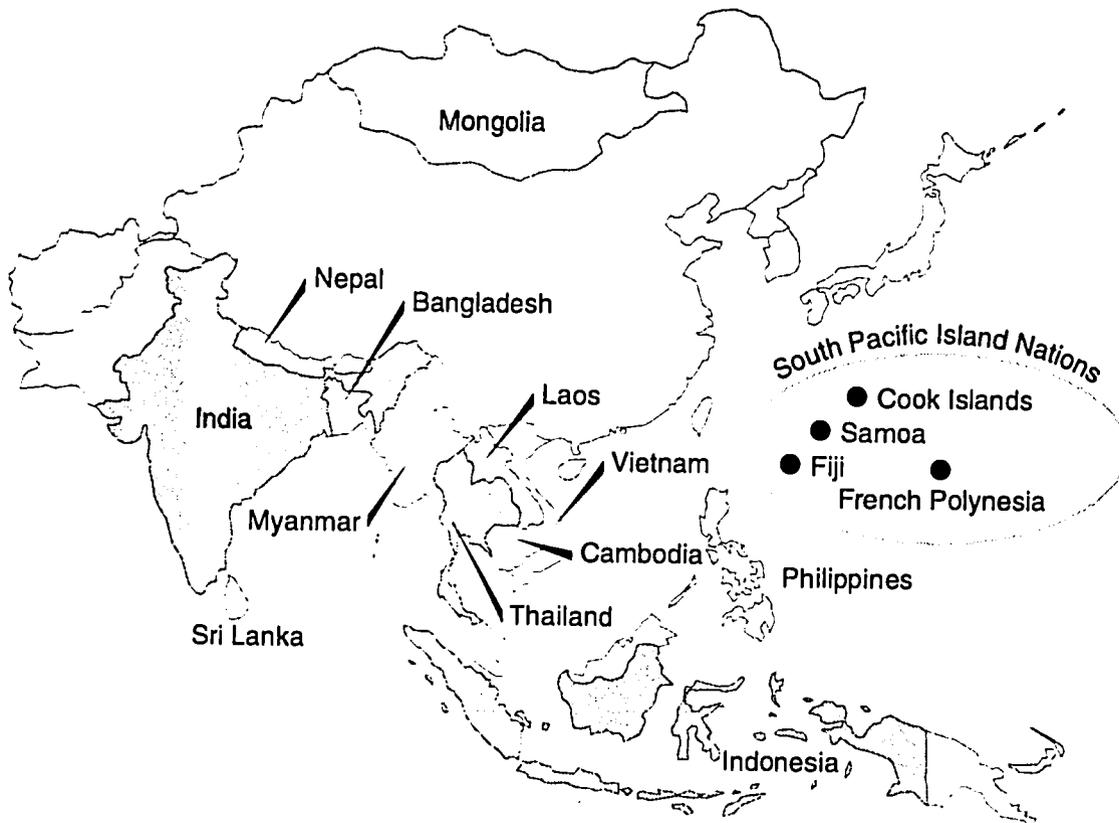
Mali process indicator data reflects activity through September 1994 except for the following missing reports: 23467 October 1992 - March 1993, May 1993, July 1993.

Lesotho process indicator data reflects activity through August 1994 except for the following missing reports: 23471 February 1993 - April 1993, February 1994.



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-  Priority Country
-  Associate Country





ASIA REGIONAL OVERVIEW

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The HIV/AIDS pandemic in Asia began relatively late despite the early presence of the disease in other regions of the world. The earliest infections were reported in the late 1980s. Infection rates throughout Asia are relatively low, although this may be a reflection of limited serosurveillance in the region. Of the estimated 14 million total HIV infections in the world as of late 1993, 2 million were in South and Southeast Asia and 25,000 were in East Asia and the Pacific. Because of the region's large and dense population and the significant presence of risk factors that speed HIV transmission, it is probable that the people of Asia will soon be coping with the world's most severe AIDS epidemic. The World Health Organization (WHO) projects that HIV will infect more individuals in Asia annually than on any other continent by the year 2000. This projection is based on factors such as the existence of a large, mobile population, active commercial sex industries throughout the region, and substantial epidemics of other sexually transmitted diseases that facilitate HIV transmission.

TRENDS IN MISSION AND COUNTRY RESPONSE

The response of governments and USAID Missions to AIDS in Asia remains mixed. While some governments, such as Thailand, implement aggressive programs, other countries have not yet accepted HIV as a priority on their national health and development agenda. India and Indonesia, the second and fourth most populous nations in the world, are both at the initial phases of launching nationwide HIV/AIDS control programs.

In 1993, USAID/Jakarta supported three policy tours for Indonesian policy makers to Thailand to study AIDS policies and prevention programs in the context of an epidemic that is more advanced and to engage in policy dialogues with their Thai counterparts. The "alumni" of these policy tours have formed an ad hoc group, calling themselves "The Bangkok Group," which took a leadership role in drafting the recently adopted national AIDS control plan. The Government of Indonesia and the USAID Mission are now finalizing the necessary agreements to initiate extensive AIDS prevention efforts through a \$20 million bilateral program.

India has experienced serious delays in implementing a serious national effort to combat HIV, in spite of respected reports that indicate that more than one million citizens are already infected. Establishment of a \$10 million dollar AIDS prevention program in Tamil Nadu State as part of USAID/Delhi's bilateral program required more than two years of negotiations with Indian officials.

Political instability in some countries, such as Cambodia, also has prevented the initiation of prevention programs. And until diplomatic relations are established between the United States and Vietnam and Myanmar, AIDSCAP will be unable to implement AIDS prevention activities in those countries.

With funding from the Asia Bureau, AIDSCAP has been able to initiate region-wide programs such as training and STD protocol development as well as HIV/AIDS assessments and projects in individual countries. One unique feature of the



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regional strategy is the focus on multicountry "areas of affinity," which allows the implementation of assessments and interventions across country borders. The Asia Bureau earmark funding mechanism diminishes the importance of the distinction between priority and associate countries within the region because it enables AIDSCAP to respond to the requests of Missions in the region, even when they have not set aside funds for HIV/AIDS control.

Given their regional rather than country-specific focus, region-wide programs funded through the USAID Asia Bureau funding allow for greater flexibility and creativity in programming. Regional program areas include policy and epidemiology, STD protocols, regional training, conferences, and a resource center.

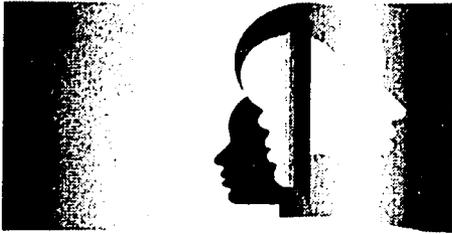
**REGIONAL
HIGHLIGHTS**

The past year was marked by a series of assessments in associate countries and areas of affinity and the start-up of two new country programs. HIV/AIDS/STD assessments were completed in Sri Lanka, Laos, and Papua New Guinea and a more focused STD assessment was conducted in Mongolia. Across areas of affinity, rapid ethnographic assessments of migrant populations were initiated and/or completed for Thai-Cambodia and the Indian subcontinent. The Thailand country program, already implementing 14 subprojects at the beginning of the year, added an additional six subprojects as the program moved from its pilot phase in six districts of Bangkok to city-wide coverage.

The year saw the start up of two country offices for associate country programs: the Philippines and Nepal. Implementation of both programs began in the second quarter of FY94.

In September 1994 the Government of India approved a tripartite agreement with USAID/Delhi and Voluntary Health Services, an NGO in Madras, to initiate the AIDS Prevention and Control (APAC) Project in collaboration with AIDSCAP. The project will begin once the final documents have been signed. Although India has been an AIDSCAP priority country, full project implementation has not begun due to the delay in signing this agreement. To date, a number of rapid-response grants have been initiated with NGOs, baseline data collection has begun, and a competitive PVO grant was awarded to PLAN International.

Other new country programs include Indonesia and Laos. USAID/Indonesia's HIV/AIDS Prevention Project (HAPP) is to be implemented with technical assistance and management support from AIDSCAP and the Centers for Disease Control and Prevention (CDC). A comprehensive associate country program in Laos was initiated last year and will begin full implementation in FY95. This program will be managed from the regional office in close collaboration with CARE/Laos.



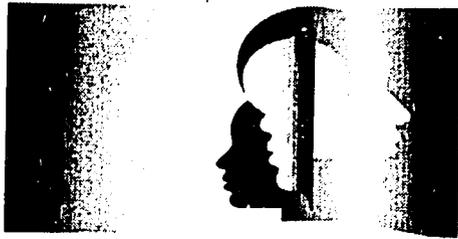
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PRIORITY

COUNTRIES

IN

ASIA



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INDIA

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India, with a population of over 900 million, has the world's largest number of poor people and the most births and deaths, as well as more cases of malaria, tuberculosis, leprosy, and many other diseases than any other country in the world. If the extrapolations from HIV testing are accurate, India, with an estimated 1 million HIV infections, has one of the highest populations of HIV-positive people in the world.

The first HIV positive people were identified in 1986. Since then over 100 surveillance centers have been established in the country. Data show that of the 2 million individuals tested so far, over 15,000 have been found to be HIV positive and about 800 AIDS cases have been reported. The latest estimate of HIV prevalence is about 0.2 percent of the population, or 1.8 million. Some small surveys among CSWs in Bombay and Madras and among truck drivers indicate that 30-40 percent of those populations are testing HIV positive.

The Government of India has initiated a US\$100 million nationwide HIV/AIDS control effort in collaboration with the World Bank, WHO, and other donors.

In 1992, AIDSCAP assisted USAID/Delhi in the design of a seven-year AIDS Prevention and Control (APAC) project in the state of Tamil Nadu, which has a population of 55 million. This bilateral project is designed to complement government efforts and will focus on mobilizing the nongovernmental organization community in the state. The NGO interventions will focus on STD control and behavior change through IEC. The government is to ensure availability of an adequate number of condoms so that the increased demand is fully met.

The modalities of the bilateral initiative are being negotiated. Though an agreement was signed in September 1992, it was not until September 1994 that the USAID Mission in New Delhi was informed by the Government of India that all formal obstacles to the implementation of the project had been removed.

USAID will fund Voluntary Health Services in Madras to manage the project. AIDSCAP will provide technical assistance and the services of a resident advisor (RA) to serve on the Project Management Committee. The RA will also undertake liaison work between the various decision makers and coordinate the provision of technical assistance. AIDSCAP will arrange for appropriate training of selected personnel in the design and management of projects and in the areas of condom promotion, STD control, and communication for behavior change. It will also provide assistance in designing useful communication materials.

While awaiting initiation of the bilateral project, AIDSCAP efforts have focused on dispersing rapid-response grants to a wide range of NGOs. Accomplishments include collecting available baseline data, initiating studies to collect baseline data where none were found to exist, assessing condom availability and accountability in Tamil Nadu, creating a database of media personnel, producing a film on a significant marginalized community of "transvestites/Hijras" affected by HIV, conducting a survey of community perception about HIV/AIDS messages, and initiating a pilot study with a mobile STD service to study its effectiveness. All



these efforts have helped establish a rapport with NGOs. AIDSCAP/APAC expects to reach a significant number of NGOs through small grants networking and by providing assistance in the form of in-country training, communication material development, STD case management training, evaluation, policy support, and condom promotion.

Through the AIDSCAP competitive PVO grant, Plan International/ Myrada received funding to work with Devadasis ("Mistresses of God"—women born into this lower caste serve as concubines within this caste) in the neighboring state of Karnataka. This activity began in August 1994 and the project staff are in place.

Truck routes linking the India-Nepal and India-Bangladesh borders have been identified as important transmission routes for HIV. The pilot intervention to protect transport workers and CSWs who serve them in this area may be initiated within a few months from USAID Asia Bureau funds set aside for area of affinity work.



INDONESIA

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Indonesia is the fourth most populous nation in the world, with an estimated population of 190 million. It is an archipelago of more than 13,000 islands stretching over 3,200 miles and three time zones. Sixty percent of the population resides on the island of Java, one of the most densely populated islands on earth. Indonesia has a crude death rate of 9/1000 and an infant mortality rate of 65/1000. The life expectancy at birth is 60 years for males and 63 years for females; the per capita GNP is approximately \$700. Approximately 85 percent of all boys and 75 percent of all girls have attended some school.

The first HIV infection was reported in 1987. Official estimates of current HIV/AIDS infection in Indonesia range from 60,000 to 80,000. As of July 31, 1994, Indonesia had 235 confirmed cases of HIV. Of these, 60 had developed AIDS. Sexual transmission predominates—96 percent of the 191 cases where mode of transmission is known were sexually acquired, and 97 percent of the 219 cases where age is known are between the ages of 15 and 49.

Conditions contributing to the rapid spread of HIV/AIDS in Indonesia include an active commercial sex industry; minimal knowledge of STDs, including HIV/AIDS; low rates of condom use (3 percent); and high STD prevalence rates among both commercial sex workers and their clients as well as groups generally considered to be at low risk, such as antenatal clinic attenders.

The Government of Indonesia (GOI) recently took several positive steps to address the epidemic. On May 30, 1994, President Suharto issued a presidential decree establishing a multisectoral National AIDS Commission. This was followed in June by the approval of a national AIDS strategy and a draft Five Year Work Plan. Several donor agencies, including USAID, are planning large-scale AIDS prevention projects to assist the GOI in program planning and implementation of its national strategy. The USAID-supported HIV/AIDS Prevention Project (HAPP) is an integrated AIDS prevention project comprised of four major technical components: a) improved management of STDs; b) IEC for behavior change; c) improved access and promotion of condoms; and d) policy support and dissemination.

As HIV/AIDS is a new health priority and the GOI is just beginning to establish a substantial HIV/AIDS prevention program, AIDSCAP activities to date in Indonesia have focused on policy support, primarily through the training of public sector decision makers in the areas of policy development, strategic planning, and IEC program development. Specific accomplishments include:

- Facilitation of four policy study tours to Thailand, involving more than 25 senior decision-makers from 16 different ministries. Policy study tour alumni have played key roles in the development of the National AIDS Program.
- Technical assistance to the Center for Health Education of the Ministry of Health in of AIDS education strategic planning and program development. A Ministry of Health AIDS team was established, with members from the Center for Health Education and the Division for Communicable Disease



Control. In cooperation with other ministries and NGOs, the AIDS team developed AIDS education strategic plans for specific target groups, emphasizing behavior change.

- AIDSCAP and the Ministry of Health cosponsored the first National AIDS Conference for Provincial AIDS Teams. As part of this conference, the provincial AIDS teams developed their own draft AIDS education work plans based on the GOI national strategy and the target-group strategies.
- Development of iwg-AIDS modules, which are being used to project the future course of HIV/AIDS and other STDs in Indonesia. Representatives of several ministries also received training in policy development and the use of models to improve decision making.
- Support for the Multilevel Assessment of Behavioral Interventions for Reduction of STD/HIV Transmission among Sex Workers in Bali. This project is implemented by Udayana University and the University of Michigan, and has the objective of increasing knowledge and awareness of STDs/HIV and condom use among low-priced female sex workers in Bali.

Implementation of HAPP activities in FY95 will center on initiation of the project, development of detailed implementation plans, baseline research, and commencement of select interventions. It is hoped that the initial stages of HAPP will be accelerated, as a result of AIDSCAP's presence in Indonesia and its already established relationships with key policy makers.



AIDSCAP

THAILAND

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Thailand has a population of approximately 60 million with a crude birth rate of 20/1000 and crude death rate of 6/1000. The Thai government's aggressive response to fighting the HIV/AIDS pandemic is quickly making this country the Asian "showcase" model for HIV prevention in the region.

The AIDSCAP Thailand program focuses almost exclusively on Bangkok, the capital, with a population of 6-8 million, at the request of the Thai Ministry of Health. The Bangkok comprehensive program, or Bangkok Fights AIDS (BFA), is targeting the lower-income groups, ages 15-29, totaling 1.5 million people, in workplaces, health service facilities, and households. The project began in mid-1992, with some city-wide activities and intensive activities in six districts of Bangkok's 38 districts. The BFA program is conducted in collaboration with over 20 agencies from both governmental and nongovernmental organizations (NGOs).

As part of AIDSCAP global strategy, the BFA aims to slow the spread of HIV by strengthening STD services, increasing the use of condoms, and reducing the number of sex partners through interactive interpersonal communication and mass media. These initiatives seek to create an atmosphere that is conducive to social norm change among the target population.

Strengthening the infrastructure of coordination for AIDS prevention work in Bangkok was one of the primary goals of AIDSCAP. When the BFA was first designed, there was no permanent governmental body to coordinate AIDS activities in Bangkok. In the interim, a Bangkok AIDS Center was created by the Bangkok Metropolitan Administration (BMA). AIDSCAP support to this center helped speed its development into the full-time AIDS Division of the BMA that exists today.

In the nongovernmental sector, AIDSCAP support to the NGO Coalition On AIDS has strengthened the collaboration between more than 40 NGOs working on AIDS nationwide, as well as increasing its visibility and recognition among the donor community and the public and private sectors. AIDSCAP has supported a full-time secretariat attached to an NGO member of the Coalition, and this has increased the effectiveness of coordination efforts. The Coalition is now able to organize a regular forum to exchange information, views, and lessons learned and to expand an interest in AIDS issues to NGOs that have not yet worked on AIDS.

In the sprawling, densely populated and diverse city of Bangkok, the mobilization of community networks and gatekeepers in various communities was paramount for the success of AIDS prevention interventions. While the AIDS Division of the BMA functions as the city-wide government coordinating body, each of the 38 districts has multisectoral "District AIDS Committees" (DACs), which were created to promote condom-only policies in commercial sex establishments. AIDSCAP support through Mahidol University has helped strengthen and broaden the mandate of these DACs in the six pilot districts to facilitate the activities of other AIDSCAP interventions in the BFA. The project was successful in providing access to hard-to-reach target groups.



To build the capacity of implementing agencies in reaching the most-at-risk populations, AIDSCAP has supported different agencies in conducting outreach to extend interpersonal communication on AIDS prevention to various workers in factories, restaurants, gas stations, garages, mass transportation, motorcycle taxis, and construction, as well as residents of slum areas. Through technical assistance from PATH/Thailand, development of different communication modules and training of outreach workers (ORWs) in using them has been standardized and improved over the life of the project.

STD services have been strengthened at the nine STD clinics of the BMA. Improvement of quality of services such as diagnosis and treatment and more complete information for clients has been observed. These improvements are reflected by the continued level of attendance at the target clinics while most STD services in other settings reported reductions in numbers of client visits. Piloting of two evening clinics yielded enough positive results that the BMA decided to propose a continuation funded from its own budget. BMA outreach education to CSWs will continue after the project ends, although at a less intensive level since the project has provided almost full coverage of CSWs in Bangkok during the past 18 months.

The AIDSCAP-supported Thai Medical Society for STDs completed a baseline needs assessment in preparation for private sector training in STDs. AIDSCAP also completed revision of a dual-gender STD handbook for the general population; completed and distributed three educational modules for outreach to 15,000 Bangkok CSWs, including an anatomical model, a six-part video drama, and a photonovella; completed a supervisory form for monitoring the performance of STD course trainees; and developed and distributed a counter-top educational flip chart on STDs for pharmacy customers.

Several information, education and communication (IEC) materials produced in the AIDSCAP projects, the most advanced in terms of content, have been well received by the target group and have sparked interest among other organizations working with similar groups. In particular, those materials targeting CSWs for co-support among peers to reinforce 100 percent use of condoms and regular check-up at STD services have been effective in supporting behavior change. Other materials that target men and women in workplaces discuss safer sex decisions quite openly. This material also was well received by the target population and is being widely duplicated (from other funding sources) to be used in other projects with similar target groups.

In the AIDSCAP campaign for communication for behavior change, all the outreach subprojects of the BFA have attempted to go beyond information giving to raise awareness; the AIDSCAP effort is directed more toward action-oriented communication. Constraints to training and equipping the ORWs to understand and recognize the multiple dimensions of sexual behavior change and to conduct effective discussions about sex with the target groups remain. However, progress has been made in strengthening ORWs' skills in using group discussion and other



AIDSCAP

interactive communication forms to involve members of the various target groups in discussing their personal sexual behavior and minimizing risks.

Thailand has more behavioral and biological data on HIV and risk behaviors than any other country in Asia. Thus, existing sources of data have been tabulated and tracked to help measure changes over time that are attributable, in part, to the Bangkok Fights AIDS program. Data more specific to AIDSCAP-funded interventions include a behavioral sentinel surveillance survey, which is conducted every six months in the same geographic areas as the BFA program. Process indicator forms provide project-specific output data and a number of the outreach programs include pre-and post-interview surveys of program participants. The greatest challenge in the coming year will be expanding the outreach interventions to all of Bangkok. The aim is to reach 200,000 people in over 2,000 worksites and communities with interpersonal communication by a trained ORW. Given the experience and lessons learned in the past year, the program should become increasingly efficient in bringing people further along on the continuum of behavioral change. Specific areas of program evolution are expected in the following:

- Strengthening the existing coordination structure
- Increased private sector leveraging
- Plans for AIDSCAP withdrawal and efforts to enhance and sustain coordination among BFA implementing partners
- Wider documentation of project experience and development of forums to present and discuss lessons learned.



Thailand Process Indicator Data

Total People Educated	59,889
Males	7,194
Females	23,930
No Gender Specified	28,765
Total People Trained	1,544
Males	147
Females	180
No Gender Specified	1,21
Total Condoms Distributed	738,441
Free	738,441
Sold	0
Media Spots Aired	0
Total Materials Distributed	110,699

Thailand process indicator data in this table reflects activity through September 1994.



Thailand Baseline Indicators⁽¹⁾

	High Risk		Low Risk ⁽²⁾	
	Males	Females	Males	Females
HIV prevalence	6.2	4.5-12.6	N/A	1.1
Self-reported STD prevalence	55	70	3-5	6-25
Knowledge of 2 preventive methods	89	33-41	81	59-65
Appropriate perception of risk	44-67	N/D	19-28	N/D
Condom use in high-risk situations	64	85-99	88	N/D
2 or more sexual partners in the last year	36-80	N/A	17-42	0.6-8
Agree that women are able to carry condoms			62	40
Agree that women should participate in sexual decision making			51	51

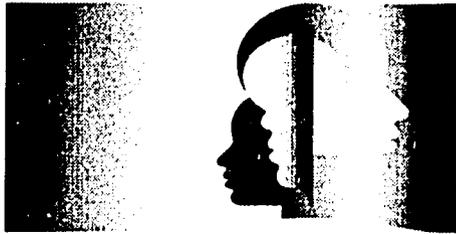
Data expressed in percentages; ranges reflect multiple populations

N/A = Not applicable

N/D = Not available at time of report

(1) = Collected before or during initial stages of implementation of AIDSCAP program

(2) = Includes "youth/adolescent" populations



AIDSCAP

ASSOCIATE

COUNTRY

PROGRAMS

IN

ASIA



NEPAL

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In Nepal, as with its neighbors in South and Southeast Asia, the population groups at highest risk of infection are those who engage in frequent, unprotected sex with multiple partners. Nepal's at-risk population includes transient, migratory groups — most particularly commercial sex workers (CSWs) and their clients. Because of Nepal's rural economy, its current economic conditions, and its unique commercial and migratory labor ties with India to the south, it was determined that Nepal's border areas and primary transport routes in the Terai/Central regions serve as the optimal location for AIDSCAP's HIV/AIDS and STD prevention interventions. To reach the targeted populations engaging in high-risk sexual practices, program activities are focused among large and small communities and in commercial centers adjacent to the Prithvi, Tribhuvan, and Mahendra highways in the Central Development Region.

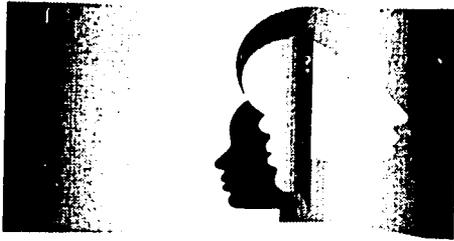
In an effort to ensure access to effective STD services at the point of first encounter, AIDSCAP is supporting the development and delivery of two training curricula for key private sector providers — private physicians and pharmacists. AIDSCAP also has begun work with the Nepal Medical Association to establish national management guidelines and has worked with the STD/AIDS Unit to develop an STD Operations Manual.

To promote the use of condoms for STD/HIV disease prevention, AIDSCAP is collaborating with The Futures Group's Social Marketing for Change (SOMARC) project to improve condom distribution and demand. The Futures Group provides assistance to the Nepal Contraceptive Retail Sales Company (CRS) to strengthen the company's condom distribution systems and expand product marketing beyond pharmacy retail shops to non-traditional sales outlets, including tea shops, bars, and hotels as well as men's and women's beauty operators in the Central/Terai Region, with innovative sales initiatives. This effort has been very successful, with the sale of 2,828,184 condoms for the period from March to July 1994.

AIDSCAP/Nepal's major outreach education subproject with a Kathmandu-based health, environment, and community development NGO, General Welfare Pratisthan (GWP), began on September 1, 1994. With human resources development assistance from a Kathmandu-based NGO experienced in community outreach services, the Lifesaving and Lifegiving Society (LALS), GWP will implement intensive community-based outreach education activities in AIDSCAP's nine target districts.

In support of the Nepal intervention strategy, limited funds are programmed to support policy reform at the national level. Plans are underway to provide direct technical support to the National Center for AIDS and STD Control to conduct a training workshop on the EPIModel and to revise Nepal's 1994 HIV infection estimates and projections. Future plans also call for an Asia regional policy tour and capacity-building media workshops for local journalists.

AIDSCAP/Nepal's baseline knowledge, attitudes, and practices behavioral survey with New ERA of 160 commercial sex workers, 300 clients, and 40 pharmacists

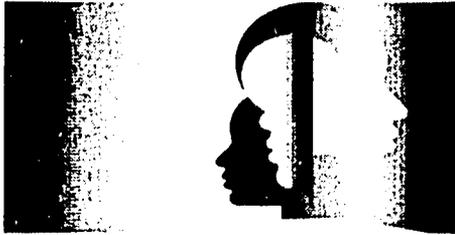


AIDSCAP

along Central Nepal's primary transport routes began in mid-1994, with an expected completion date of November 1994. The survey was appropriately timed with intervention implementation, and the results will be critical to the development of subproject communication strategies and IEC products.

Over the remaining 24 months of the AIDSCAP/Nepal program, the primary focus will be on the field-level implementation of the STD workshops, the condom distribution and communication campaign, and intensive, community-based outreach education activities.

Unlike other HIV/AIDS initiatives underway in Nepal, the AIDSCAP/Nepal strategy integrates critical, mutually reinforcing prevention activities in a focused geographical area. The AIDSCAP strategy places significant weight on the coordination of its implementing agencies to facilitate important subproject objectives such as the social marketing of condoms by peer leaders, the support of community outreach events by local businesses, and the sustainability of local rapid-response fund grantees.



AIDSCAP

LAOS

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The HIV/AIDS epidemic in the Southeast Asian country of Laos is at a relatively early stage compared to many other countries. However, Laos is rapidly approaching the exponential growth phase of the HIV epidemic curve that, without intervention, will result in an explosion of the number of people infected with HIV.

An initial HIV/AIDS assessment of Laos was conducted by AIDSCAP with CARE/Laos and local consultants in February 1994. In the next year, an AIDSCAP/Laos country program will begin implementation. Activities based on the strategic and implementation plan will include behavior change communication, STD prevention and control, and condom promotion. During the initial phase, AIDSCAP will conduct formative research about risk perceptions and the context of risk behavior for AIDS and STDs, lifestyles, and how to best reach different target groups taking into account ethnic differences.



PHILIPPINES

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The Philippines has a population of approximately 68 million with a crude birth rate of 28/1000 and a crude death rate of 7/1000. As of August 1994, there were 544 reported cases of HIV infection. There are, however, an estimated 25,000 HIV-infected individuals. HIV prevalence from the sentinel surveillance is less than 1 percent. Sexually transmitted disease (STD) status has not been well-defined due to underreporting from the private sector as well as from the government sector. Antenatal syphilis screening has not been done regularly.

USAID/Manila is currently implementing a USD 6.5-million AIDS Surveillance and Education Project (ASEP). AIDSCAP's one-year contribution aims to assist the Department of Health in establishing priorities and selecting appropriate strategies for STD control in the Philippines. AIDSCAP is providing assistance to the STD/AIDS Unit, Department of Health to: 1) define the magnitude and patterns of the STDs; 2) identify priority target populations and their STD disease perceptions; 3) describe the current STD health-seeking behavior and perceptions of STD among commercial sex workers (CSWs) and their clients; 4) assess the current STD management practices of private practitioners and pharmacy staff; and 5) assist in the development of national STD management guidelines based on epidemiological, laboratory, and antibiotic situations.

AIDSCAP funded a survey among women attending the antenatal clinic at the Philippine General Hospital (PGH) in Manila and among commercial sex workers in Metro Manila and Metro Cebu. The study was conducted by the Obstetrics and Gynecology Department of PGH and Cebu City Health Department in collaboration with Kabalikat and the Health Action Information Network (HAIN). It estimated the prevalence of STDs in the general population and commercial sex workers and identified socio-demographic, clinical, and behavioral characteristics of women and their partners that might help identify women at higher risk for STDs in the general population.

For the next five months, AIDSCAP will fund a targeted intervention research study to identify the STD disease perceptions and health-seeking behaviors of CSWs and men at high risk for STDs in Metro Manila and Metro Cebu. This research will be conducted by the University of the Philippines, College of Public Health, to answer programmatic STD control issues in order to create effective and sustainable STD services. AIDSCAP will also look into the management practices in the private sector, including those by private practitioners and pharmacy staff. This study of private sector STD management will be conducted by the Philippines Society of Venereologists and the Philippines Pharmaceutical Association.

The data obtained from all these studies will enable AIDSCAP to assist the Department of Health to develop a rational and appropriate five-year STD control plan.



AIDSCAP

BANGLADESH

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Bangladesh is the most densely populated country in the world, with a population in 1994 estimated to be 117 million, about 85 percent of whom are Moslem. The threat of the increased spread of HIV/AIDS within Bangladesh is linked to its proximity to India, Myanmar, and Thailand, where the HIV/AIDS epidemic is firmly entrenched. Only three AIDS cases and 20 HIV infections have been reported to the Ministry of Health and Family Welfare (MOHFW) in Dhaka.

In FY93, the USAID Asia Bureau allocated funds to AIDSCAP for an initial assessment, strategic design, and beginning policy dialogue with Bangladesh government officials. However, the USAID/Dhaka Mission was not ready to involve itself in HIV/AIDS prevention work on a large scale. The Mission was interested in providing training for members of the STD/AIDS Network.

As requested by USAID/Dhaka, AIDSCAP visited Dhaka in April 1994 to assess the training needs of the NGOs who are members of the STD/AIDS Network. As an outcome of the assessment, the USAID/Dhaka Mission asked AIDSCAP to organize a four-day competency-based workshop for training coordinators of the STD/AIDS network in the provision of quality HIV/STD education. This workshop will take place in the next fiscal year.



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MONGOLIA

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The HIV/AIDS epidemic in Mongolia is at an early stage compared to other regions of the world. To date, only one Mongolian with HIV infection has been reported. Among the 3,581 STD patients, 439 CSWs, 26,863 pregnant women, and 69,280 blood donors tested in Ulaanbaatar since 1987, not a single HIV infection has been detected so far. The first round of sentinel surveillance, which began in June 1994, is limited to testing STD patients and CSWs every six months, using informed consent forms and pre- and post-test counseling.

With funds from USAID's Asia Bureau, AIDSCAP participated in the development of the National AIDS Program's (NAP) Second Medium-Term Plan in May 1994. Recommendations from the team included improved STD case management, development of national guidelines based on syndromic diagnosis, communication strategies for behavior change, improving access to quality condoms and their distribution, centralizing the management structure of the for AIDS and STD programs, and policy advocacy.

In the next fiscal year, AIDSCAP will work with Mongolia's Ministry of Health to improve STD case management. Specific activities will include: standardizing national STD case management guidelines in both the government and private sectors; identifying essential antibiotics for the treatment of STDs to be included on the National Essential Drug List; developing STD/HIV education materials for distribution at clinics; developing a course on STD case management (including diagnosis, treatment, prevention education, and condom promotion and distribution); advocating for the establishment of a condom distribution system in STD clinics; and encouraging the participation of Mongolians in AIDSCAP regional workshops on communication strategies in HIV/AIDS prevention.



SRI LANKA

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Sri Lanka is an island nation of approximately 17.6 million (1992) located off the southern coast of India. Twenty-two percent of the population lives in urban areas, and the majority of the population is concentrated in the south and west. The first HIV infection was detected in September 1986. As of November 15, 1993, 118 persons had tested positive for HIV antibodies. A rapid assessment of the STD situation was by the World Health Organization in 1991, estimated that more than 200,000 STD infections occur annually in Sri Lanka.

Early in fiscal year 1994, USAID/Colombo requested AIDSCAP to review the HIV/AIDS epidemiological situation and the response to date in Sri Lanka. In addition, the team proposed a strategic framework for the current nongovernmental organization AIDS prevention projects funded by USAID and made more general recommendations on areas in need of attention from other donors, the Government of Sri Lanka, and NGOs.

Primary recommendations to USAID/Colombo included providing (1) STD clinic outreach to CSWs in Colombo; (2) STD management distance learning modules; (3) training opportunities in HIV/STD policy and behavior change communication; (4) NGO capacity building in HIV/AIDS prevention through NGO coordination, policy/advocacy, and training; and (5) technical assistance in human resource development, policy process, and evaluation strategies.

The STD distance learning module has been well received by Sri Lankan counterparts and the USAID Mission. This concept is being developed into a subproject, which should begin implementation in FY95. No further projects are planned at this time.



AREAS

OF

AFFINITY

IN

ASIA



THAILAND/ MYANMAR

82

Although Thailand and Myanmar (formerly Burma) are increasingly divergent economies and societies, the two share a porous border thousands of kilometers in length.

Several years ago the U.S. Congress earmarked a sizable amount of money to assist Burmese displaced persons on the Thai side of the border. Part of this assistance package was to be for HIV prevention education. In order to assist the NGOs in planning their HIV/AIDS component, USAID's Asia Bureau gave funds to AIDSCAP to conduct a strategic assessment of border migrants. At the same time, the Thai government was coming under increased pressure to account for its activities in support of Burmese refugees and to avoid the appearance of providing assistance to any group that might be opposed to the Burmese government. Because of the sensitivity of working with populations on the Thai-Myanmar border at the present time, the USAID Regional Support Mission has requested that AIDSCAP postpone plans for an assessment until April 1995, when these plans can be reconsidered. Thus the funds for a Thai/Myanmar border migrant assessment will not be reprogrammed at present. AIDSCAP will continue to monitor the epidemic among the ten Thai provinces that border Myanmar through sentinel surveillance data and STD services statistics.



THAILAND/ CAMBODIA/ VIETNAM

This area of affinity, defined again by common borders, was shaped to determine the special risks of people in this border area related to HIV/STD transmission. Political constraints have slowed activities in this area. U.S. government restrictions on Vietnam have not allowed for any in-country assessment of the epidemic. Data from Vietnam suggest an already entrenched epidemic, and Vietnamese Ministry of Health officials are anxious to work with donors. In the meantime, a Thai-Cambodia border assessment is underway.

In Cambodia, the potential for the spread of HIV is high. Two hundred pregnant women living on the Thai-Cambodian border were screened for HIV in 1994 and 10 percent were HIV positive. This level of prevalence in a normally low-risk group is higher than that of all but two of Thailand's 73 provincial sites in the December 1993 sentinel surveillance. Clearly Cambodia is on the verge of becoming host to one of Asia's worst epidemics.

In mid-1994 AIDSCAP was able to commission an assessment of border migrants to explore the range of risk behaviors and the potential for interventions in the areas of greatest population movement between the two countries. Rapid ethnographic assessments are part of the AIDSCAP strategy and are being used to define the highly mobile groups of border migrants, transport workers, fisherman, and commercial sex workers in Asia.

Two sites were chosen for the Thai-Cambodian border assessment: Hat Lek at the tip of Trad Province, where the land border joins the Gulf of Thailand; and Aranyaprathet in Prachinburi Province. Currently the assessment report is still being prepared. Preliminary results from the Hat Lek phase of the assessment confirmed that a high risk of transmission is present and is diffusing to otherwise low-risk but more numerous populations. The final report of this assessment will provide recommendations for potentially cost-effective interventions.



INDONESIA/ PHILIPPINES

84

AIDSCAP Indonesia - Philippines AOA activities are currently in the very early stages of development. The primary activity, implemented by PATH/Indonesia, is an assessment of HIV/AIDS risk in five Indonesian cities where significant cross-border transportation networks are evident. The goal of the activity is to assist the Government of Indonesia and other interested parties to gain a more complete understanding of the context in which HIV may be transmitted and the resources available for prevention programming. PATH and AIDSCAP are in the process of developing an assessment tool. It is expected that the first assessment will be initiated in mid-October, with completion of all five assessments expected in early 1995.



SOUTH PACIFIC ISLAND NATIONS

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There is a great deal of commerce and traffic among the ten nations of the South Pacific area, including Fiji, Papua New Guinea, the Cook Islands, and Western Samoa. Fiji is a major tourist attraction for Westerners as well as a regional training center for the South Pacific. The regional commercial center, Papua New Guinea, receives a large number of business travelers. AIDSCAP activities in this area of affinity are concentrated in Papua New Guinea at the request of USAID/Suva.

As of December 1993, a total of 153 HIV-infected people had been reported in Papua New Guinea (PNG), including 57 people with AIDS. Expanding from WHO/GPA estimates in 1992, it is probable that between 10,000 and 30,000 people are currently infected out of a population of 4 million.

An initial assessment of the HIV/STD situation in PNG was completed in November 1993 by AIDSCAP staff and a local medical anthropologist from the PNG Institute of Medical Research. The team recommended that intervention activities begin with individuals employed in the transport industry working between Lae and Mt. Hagen on the Highlands Highway and along the coastal routes between Lae and Madang. Target groups include long-distance truck drivers and their assistants, people working at truck stops, public motor vehicle (PMV) drivers, seamen, and waterside workers.

To set the stage for intervention activities, a rapid ethnographic assessment of the transport industry was completed over a four-month period. The final report, submitted in September 1994, confirmed expectations that sailors and truckers are frequent buyers of commercial sex. A simultaneous study of CSWs in Lae, Goroka, and Port Moresby demonstrated that in some cases, the seller-to-buyer ratio is high, perhaps as great as 1 to 15. More than half of all the sailors and truckers interviewed stated that they had at some time experience a sexually transmitted disease. In general, condom usage was low, particularly among older truckers and sailors who were more resistant to the idea of a condom than younger men.

With the closing of the USAID Mission in PNG in September 1994, no further USAID funded projects may continue. Therefore, although a significant number of recommendations for reaching these target groups with appropriate interventions have been proposed, AIDSCAP is unable to act on them. As a final closeout step, AIDSCAP assisted staff from the PNG Institute of Medical Research to design an STD/AIDS prevention project proposal for submission to the Australian International Development Assistance Bureau in August 1994.



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INDIAN SUBCONTINENT

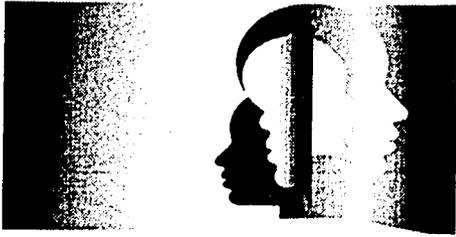
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The northern states of India that border Nepal and Bangladesh are characterized by massive populations and pervasive poverty. Bihar and West Bengal are threatened by HIV because they are placed on the highway crossroads connecting Nepal with Bombay, Calcutta, and Bangladesh. Every day and night, thousands of trucks ply the roads of Northern India, transporting vital goods among the three countries.

The potential for a disastrous HIV epidemic is suggested by seroprevalence data from a voluntary testing and counseling service for truck drivers near Calcutta. The current level of HIV had already reached 7 percent by mid-1994.

In late FY94, AIDSCAP, with USAID Asia Bureau funds, sponsored an assessment on the routes from Calcutta to Nepal and from Calcutta to Bangladesh to assess patterns of truck driver behavior, formats of commercial sex, and condom availability and to explore the availability of indigenous infrastructure to provide STD counseling, diagnosis, and treatment. The assessment is ongoing along the eastern truck routes in West Bengal.

Limited amounts of AIDSCAP funds are available for an initial expansion of other effective truck driver interventions in India to this geographic area. Other sources of funding are needed for sustained services. Leveraging funds from the lucrative Indian trucking industry is one possibility that is being explored. Without a rapid, targeted intervention soon, the epidemics in northern India and along truck routes into Nepal and Bangladesh may easily flare out of control.



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-  Priority Country
-  Associate Country





LATIN AMERICA AND THE CARIBBEAN REGIONAL OVERVIEW

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CHARACTERIS- TICS AND TRENDS

Latin America and the Caribbean (LA/C) reflect the continuum of the HIV/AIDS epidemic worldwide. The spectrum begins with countries such as Jamaica and other small Caribbean islands, where less than one percent of the general population is infected with HIV. A moderate level of infection is evident in the large industrial and port cities of Brazil, Honduras, and the Dominican Republic, where the HIV pandemic is no longer concentrated in the homosexual/bisexual population but is increasingly transmitted heterosexually. The results are rising rates of infection among women and increased vertical transmission (from mother to infant). The highest levels of HIV infection in the region are reported in Haiti, where the epidemiology of HIV/AIDS is very similar to that of sub-Saharan Africa, with a nearly 1:1 male-to-female ratio and seroprevalence among low-risk populations between 6 and 10 percent. In response to the growing epidemic in the region, USAID Missions throughout LA/C have requested AIDSCAP assistance in developing programs that will strengthen host-country efforts to slow the spread of HIV/AIDS.

One of the unique challenges to HIV prevention efforts within the region are the cultural norms that promote multiple sex partners and increase the potential for transmission. For example, in Central and South America many self-identified heterosexual men will occasionally have sexual relations with other men (usually in all-male settings where migrant labor, war, or other factors allow little contact with women). These men do not identify themselves as homosexual or even bisexual, and they often are targeted through workplace programs. The traditional opposition of the Church to family planning and sex education has erected barriers to efforts to increase condom use in high-risk situations.

Society as a whole has been resistant to accepting the threat of AIDS. Instead, it is often viewed as a foreign problem. Even where there is acceptance of HIV/AIDS as a health problem, there is little understanding of the threat it poses to socio-economic development. Many other health problems compete with HIV/AIDS for the inadequate funds available for health care in the region, and HIV prevention receives inadequate priority. Finally, there is widespread ignorance of the social, political, and human rights aspects of the epidemic.

TRENDS IN MISSION AND COUNTRY RESPONSE

The enthusiastic acceptance of the AIDSCAP Women and AIDS Initiative in LA/C priority countries shows that countries in the region have realized the importance of addressing women's HIV/AIDS prevention needs. In the Dominican Republic, a project with youth amended its scope of work to include training workshops for 25 women health promoters. After completing training on health-related issues from a woman's perspective, these health promoters will incorporate knowledge gained from the workshops into their future activities and will train fellow health promoters. AIDSCAP/Brazil sent a representative to the regional NGO preparation meeting for the United Nations World Conference on Women in Beijing in 1995 to



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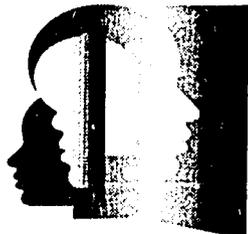
assure representation of women's health issues related to HIV/AIDS/STDs. A representative from the Brazil office was also invited to participate in a conference on perinatal HIV/AIDS and women sponsored by the Gynecology and Obstetrics Association of Argentina. Haiti continues support of an education and communication project with women factory workers, and the AIDSCAP/Jamaica evaluation implementing agency completed a study and report on "Sexual Decision Making and Barriers to Initiating Condom Use in Married Relationships - A Female Perspective." The LA/C Regional Office is cooperating with the Women and AIDS Initiative to design a proposal for a regional strategy for Central America that explores initiation of women's projects in addition to possible incorporation of gender-specific activities into existing subprojects.

**REGIONAL
HIGHLIGHTS**

During the past year, the LA/C Regional Office has emphasized the importance of mobilizing the private sector in order to create a positive workplace environment in which to implement HIV/AIDS activities, to generate further resources for these activities, and to promote sustainable and replicable workplace prevention models. Two subagreements were approved with Shell Brazil, S.A., to reach people in the workplace and men away from home. AIDSCAP funding and technical support for these projects leveraged a contribution of over USD 244,000 from Shell. In the Dominican Republic projects are underway with 58 factories in the Haina industrial zone as well as with employees of the hotel industry in Puerto Plata. Factory-based HIV/AIDS prevention projects also continue in Haiti and Mexico. A final report for the Honduras socioeconomic impact study was finalized and a video was produced, which will facilitate the dissemination of the study's results at future policy presentations and private sector meetings in Honduras and throughout Central America.

Youth remain a focus of AIDSCAP programs throughout Latin America. In Costa Rica an HIV/AIDS curriculum was developed for school-age adolescents. All of the AIDSCAP/Dominican Republic implementing agencies participated in the design of a mass media campaign aimed at adolescents that will begin in the first quarter of FY95.

The LA/C Regional Office continues to meet the requests of USAID Missions in AIDSCAP associate countries. An AIDSCAP team traveled to Guatemala in August to conduct a technical assessment of the epidemiologic status of HIV/AIDS and STDs and the response from the National AIDS Prevention and Control Program, international donor organizations, NGOs, and the religious sector. AIDSCAP developed plans for a project in Nicaragua to conduct behavioral research with high-risk groups and to interview opinion leaders about HIV/AIDS. The results of this research will be used to develop a communications strategy with the NACP. The groundwork also has been laid for three socioeconomic impact studies in Nicaragua, El Salvador, and Guatemala during the next fiscal year.



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PRIORITY

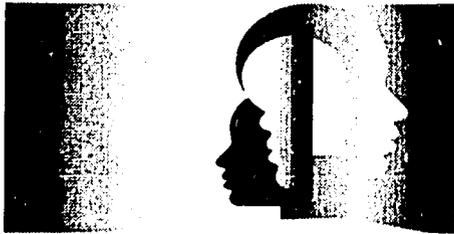
COUNTRIES

IN

LATIN AMERICA

AND

THE CARIBBEAN



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BRAZIL

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Brazil is the world's fifth largest country in geographic size and also in population. With over 153 million inhabitants, Brazil has a crude birth rate of 26/1000 and a crude death rate of 7/1000, giving it an annual rate of natural increase of 1.9 percent.

Brazil has the fourth highest reported number of AIDS cases in the world. According to figures from the Ministry of Health, 53,326 AIDS cases had been reported through June 1994, with 68.9 percent coming from the highly urban southeastern region of the country. The male-to-female ratio in adults has decreased from 9:1 in 1987 to 4:1 in 1994.

The HIV/AIDS epidemic is exacerbated by high rates of STDs among high-risk populations. For example, among female prostitutes in the state of São Paulo, prevalence rates for syphilis are 69 percent in the city of Santos, 63 percent in Campinas, and 66 percent in the state capital São Paulo. Almost 100 percent of chancroid patients in the city of São Paulo are infected with HIV.

Brazil was one of AIDSCAP's earliest priority countries. AIDSCAP has provided technical leadership for replicable programs in Brazil and has concentrated its efforts in major urban areas in the states of São Paulo and Rio de Janeiro. The criteria for selection of the two geographic regions included incidence and prevalence of HIV infection, potential for impact, governmental and nongovernmental infrastructure and resources, and potential for collaboration. Four high-risk populations have been targeted: male and female CSWs, men who have sex with men, men away from home, and people with STDs and their partners. Recently, AIDSCAP initiated support for a project to help thousands of street children prevent STDs and HIV infection. Since 1992 AIDSCAP has implemented an integrated and comprehensive technical approach in targeted geographical areas. The AIDSCAP country office has worked in close collaboration with governmental and nongovernmental organizations as well as the private sector in the target areas.

Condoms are being provided through a social marketing program by DKT do Brazil/PSI. During fiscal year 1994, a total of 9,670,000 condoms were sold. This represents a 43 percent increase in sales over 1993. The price of the Prudence brand, the socially marketed condom, is one-fourth that of the other local brands. This program reaches beyond the targeted populations with messages and sales outlets to the rest of the country and the general population.

In the cities of São Paulo, Rio de Janeiro, and Santos, the expansion of STD care and management is being carried out in collaboration with the public sector. To date 466 health care providers have been trained and 27 health clinics have been upgraded for the diagnosis and treatment of STDs. Counseling is being provided to all patients. In addition, the city of Santos has trained 31 pharmacy clerks from 20 drugstores on STD/HIV/AIDS prevention issues.



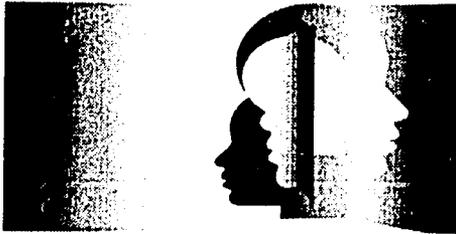
In 1994 USAID and AIDSCAP collaborated on the donation of 7.6 million condoms that are being distributed primarily through public sector clinics. In order to establish logistics systems for STD/AIDS pharmaceutical supplies and condoms, computers, printers, and software were donated to the Departments of Health in the states of Rio de Janeiro and São Paulo as well as the federal Ministry of Health. Training and extensive technical assistance was provided in their use, and an Essential Commodities Management Information System (ECMIS) was installed for data processing and data collection.

The USAID/AIDSCAP-supported subprojects are using multifaceted, integrated behavior change communication (BCC) techniques such as: audio-visual and printed materials, face-to-face education, theater, and role play, all adapted to the individual target group and provided at appropriate locations. All BCC activities utilize a participative approach. Qualitative and quantitative research, as well as monitoring activities, provide feedback for the refinement of the interventions. A computerized inventory of all HIV/AIDS/STD materials produced in Brazil was recently completed.

AIDSCAP has played a key role in affecting policy. Chief among the program successes has been the federal governments' decision to exempt condoms from a 17 percent import tax. In addition, by presidential decree, condoms were exempted from the 15 percent tax on industrialized products. AIDSCAP/Brazil played a major role in the process of lobbying for the exemptions, together with the MOH and local NGOs. The effect of these changes is to bring the price of condoms within the means of a greater portion of the Brazilian population.

AIDSCAP has been very successful in using its funding to leverage additional investment from the private and public sectors in HIV/AIDS prevention activities. Nearly USD 2.6 million is being leveraged to greatly increase the sustainability of project activities.

Future plans include wider dissemination of the design, implementation, and results of the USAID/AIDSCAP-supported projects. AIDSCAP has been laying the groundwork for implementation of a wider prevention program with World Bank funding. The Ministry of Health of Brazil has signed a loan from the World Bank for USD 160 million, which, together with the Government of Brazil's counterpart contribution of USD 90 million, brings the total budget for the government's HIV/AIDS/STD control project to USD 250 million. AIDSCAP has been filling the gap until this program gets underway, as well as developing sustainable, replicable programs. The greatest impact of the AIDSCAP/Brazil program may lie in its provision of models for prevention programs throughout the country.



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Brazil Process Indicator Data

Total People Educated	126,088
Males	41,818
Females	18,846
No Gender Specified	65,424
Total People Trained	1,579
Males	273
Females	579
No Gender Specified	727
Total Condoms Distributed	17,572,071
Free	5,798,977
Sold	11,773,094
Media Spots Aired	6,265
Total Materials Distributed	480,937

Brazil process indicator data in this table reflects most activity through September 1994 except for the following missing data: 23464 December 1993; 26447 December 1993; 26450 December 1993; 21445 July through September 1994; 22447 September 1994; 23463 January through March 1994.



Brazil Baseline Indicators⁽¹⁾

	High Risk		Low Risk ⁽²⁾	
	Males	Females	Males	Females
HIV prevalence	12-25	21-67	N/D	N/D
Syphilis prevalence	N/D	27	N/D	N/D
Knowledge of 2 preventive methods	N/D	N/D	N/D	N/D
Appropriate perception of risk	85	85	N/D	N/D
Condom use in high-risk situations	73-96	73-96	N/D	N/D
2 or more sexual partners in last 3 months	N/D	N/A	N/D	N/A
Can identify clinic source for STD treatment	49	49		

Data expressed in percentages; ranges reflect multiple populations

N/A = Not applicable

N/D = Not available at time of report

(1) = Collected before or during initial stages of implementation of AIDSCAP program

(2) = Includes "youth/adolescent" populations



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DOMINICAN REPUBLIC

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The Dominican Republic (DR) shares the island of Hispaniola with the neighboring country of Haiti. The Dominican Republic has an overall population of over 7 million. Life expectancy is estimated at 67 years and the adult literacy rate is 84.3 percent. The per capita GNP adjusted for local purchasing power is USD 3,080. The Dominican Republic's Human Development Index is 0.638, giving it a global ranking of 59th.

The first AIDS case in the Dominican Republic was reported in 1983. By August 1994, the National AIDS Control Program reported 2,536 AIDS cases. Since under-reporting is estimated at 50-70 percent, it is difficult to determine the actual number of cases. The male-to-female AIDS case ratio has decreased from 7:1 to 2:1. With a 1 percent HIV seroprevalence rate among prenatal women and a rate near 10 percent in CSWs, it is evident that the Dominican Republic has a well established and rapidly expanding epidemic. It is estimated that the DR has more than 100,000 HIV-positive individuals, and this number could increase dramatically in the next few years. Recent projections estimate as many as 300,000 HIV-positive adults (about 5 percent of the total population) by the year 2000.

In September 1993 the AIDSCAP program began in the DR after the transition from the former AIDSTECH and AIDSCOM projects. The AIDSCAP/DR program responds to the rapid spread of the epidemic in the general population. During the first year, its main objectives have been to raise general awareness of the severity of the epidemic in the country and to leverage private and public sector interest and support for AIDS prevention. Another of its main objectives has been to strengthen the capacity of local organizations to implement HIV/AIDS prevention activities.

AIDSCAP focuses primarily on providing assistance to the nongovernmental sector in the DR, enhancing the existing community-based NGOs and exploring ways to expand their contribution to HIV prevention. However, AIDSCAP has provided a limited amount of support to the NACP, specifically for HIV surveillance data collection, processing, and dissemination. AIDSCAP also has provided the NACP with technical assistance and logistical support for the development of the "National IEC Strategy for HIV/AIDS Prevention." In the near future AIDSCAP will assist the NACP and the nongovernmental agencies in furthering the implementation of the national IEC strategy.

AIDSCAP Dominican Republic program is actively involved in increasing the capacity of local organizations to design, implement, and monitor HIV/AIDS and STD programs. It has continued to strengthen the local NGOs that are conducting subprojects among core groups. These groups include commercial sex workers and their clients, bar/brothel owners, men who have sex with men, hotel employees, industrial zone workers, and adolescents. The AIDSCAP/DR program aims to increase access to and improve the quality of STD services. To accomplish this, a training program based on the algorithmic approach to STD treatment is being designed. Six Dominican physicians were trained at the University of Washington in Seattle WA. The training program will be replicated in-country for clinicians and health promoters throughout the DR.



In order to better assess condom availability and accessibility, a national condom retail audit is being conducted. Results will be available in November 1994. Technical assistance and training in logistics management and distribution strategies have been provided to the public and private sectors. This has improved the understanding of why and how coordination among donor agencies and local implementors is necessary for effective condom distribution. The leading AIDS NGOs have signed an agreement on condom logistics and distribution strategies.

The Centro de Orientación e Investigación Integral (COIN) is currently implementing three AIDSCAP subprojects (with CSWs, MWM, and industrial workers). An inter-institutional agreement between COIN and the NACP was signed to coordinate efforts in technical assistance, educational material distribution, and STD clinical services and referrals. This mutual support and open communication enhances the NGOs' and the NACP's ability to reach a greater segment of the population.

COIN and the Comité de Vigilancia y Control de SIDA (COVICOSIDA) have unified project criteria in a joint effort to develop systematic behavior change interventions targeting CSWs and their clients and brothel owners. They meet regularly to share educational methodologies and strategies and collaborate in training and educational activities. They have also integrated new topics into their educational interventions to empower women and build their self-esteem. These efforts will increase the women's skills for negotiating condom use with their regular clients.

CASCO and IDDI (Institute Dominicano de Desarrollo Integral) have integrated their efforts and are jointly executing the Project ACUARIO. This project targets adolescents in four marginalized barrios in Santo Domingo, promoting safer sexual behavior. As part of its overall strategy, the project also reaches parents, schools, and local community-based organizations (CBOs). Approximately 75 percent of the CBOs targeted for this project have been contacted. Eighteen CBOs have participated in the project during this period. CASCO/IDDI also reach youth at popular events, such as sports, games, and concerts.

AIDSCAP/DR has provided short-term support to other CBOs working in AIDS prevention. Some activities AIDSCAP has financed were: World AIDS Day celebrations and an Easter week AIDS educational campaign, training of trainers for Peace Corps volunteers, and AIDS awareness at the National Basketball Championships. Collaboration was received from the private and public sectors, religious groups, radio stations, the police force, and other donor agencies such as PAHO and UNFPA.

To continue NGO capacity building efforts, a local firm has been identified to assist in defining their institutional development and sustainability plans.

In summary, the AIDSCAP/DR program has been working steadily towards achieving the objectives outlined in the overall strategic plan. It has supported a variety of activities designed to raise awareness of HIV/AIDS/STDs, including educational and informational campaigns and coordination efforts with both the



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private and public sectors. A major accomplishment has been increasing awareness of the severity of the AIDS epidemic in the DR among national policy makers. A presentation to cabinet members and religious leaders in October 1993 led to increasing levels of government support for the NACP and was instrumental in having an AIDS law enacted.

The development of the national IEC strategy for HIV/AIDS prevention has been another major achievement. It has provided a mechanism by which various public and private organizations coordinate IEC activities. This strategy enabled the NACP to leverage other donor support.

Dominican Republic Process Indicator Data

Total People Educated	375,836
Males	116,332
Females	143,567
No Gender Specified	115,937
Total People Trained	7,726
Males	3,867
Females	3,830
No Gender Specified	29
Total Condoms Distributed	1,006,363
Free	434,286
Sold	572,077
Media Spots Aired	225
Total Materials Distributed	515,823

Dominican Republic process indicator data in this table reflects activity through September 1994.



Dominican Republic Baseline Indicators⁽¹⁾

	High Risk		Low Risk ⁽²⁾	
	Males	Females	Males	Females
Syphilis prevalence	7	7	N/D	N/D
Knowledge of 2 preventive methods	60-80	80	60	60
Appropriate perception of risk	20-30	30-33	N/A	N/A
Condom use in high-risk situations	20-37	80	29	6
STD treatment according to national guidelines	N/D	80	N/A	N/A
2 or more sexual partners in last year	20	20	N/A	N/A
Youth reporting one regular sexual partner in last 3 months			50	50

Data expressed in percentages; ranges reflect multiple populations

N/A = Not applicable

N/D = Not available at time of report

(1) = Collected before or during initial stages of implementation of AIDSCAP program

(2) = Includes "youth/adolescent" populations



HAITI

100

Haiti covers the western third of the island known as Hispaniola, the second largest of the Caribbean islands. The country has a total population of 6.7 million, a crude death rate of 12/1000, and an infant mortality rate of 86/1000. Forty percent of the population is under 15 years of age. Adult literacy is 37 percent for men and 33 percent for women. About half of all health services are provided mainly by the NGOs and PVOs. Currently the public sector accounts for only 40 percent of the health services.

The first case of AIDS among Haitians occurred in early 1979. Since then, the number of reported cases has climbed to almost 5,000 as of 1993, with under-reporting estimated at 80 percent. The sex ratio of cases is nearly 1:1. HIV prevalence in high-risk urban groups, such as commercial sex workers (CSWs) and their clients and STD or TB patients, has been estimated at around 42 percent. Urban and rural Haitians in the general population are believed to have infection rates of 8 percent and 5 percent, respectively. Syphilis seroprevalence was estimated at 11 percent in antenatal attendees in 1993.

The AIDSCAP program was built on AIDSTECH projects designed with Mission funding in April 1991 to address the severity of the AIDS epidemic in Haiti. The country's strategic plan was revised in August 1992 to compensate for the withdrawal of donor support to the public sector after the military coup d'état in September, 1991. The strategy targets adolescents, commercial sex workers, private sector health care providers, and sexually active men and women in the general population. Prevention efforts involving these target groups are supported by educational material development, increasing awareness among decision makers and leaders, development of sexually transmitted disease training centers, capacity building for nongovernmental organizations (NGOs), and condom social marketing.

The program was concentrated originally in urban and suburban areas. Now that HIV is gaining a foothold in the countryside, AIDSCAP is giving more attention to rural areas, reaching six out nine health districts, while encouraging other agencies such as CARE, PAHO, and UNDP to work in the areas not yet served.

Despite severe political and economic constraints, AIDSCAP has successfully implemented eight peer education and outreach subprojects, reaching the urban poor, CSWs and their clients, factory workers (male and female), poor urban youth, sexually-active populations of the Central Plateau, and adolescents in general.

AIDSCAP performed a baseline assessment of STD prevalence in antenatal women at Centre Pour Le Developpement et La Santé (CDS). This data was used as baseline for developing syndrome management guidelines and for PAHO's selection of antibiotics for STDs. A plan was finalized with CDS, an NGO, for STD control in poor Haitian communities, integrating biomedical STD control with BCC and condom use promotion at the community level. This subproject includes systematized, routine prenatal syphilis screening, counseling, and partner notification and treatment.



AIDSCAP also developed a quality control program to monitor syphilis screening throughout the CDS system and wrote a study protocol to evaluate the effectiveness of serologically testing contacts to syphilis as a means of case identification. The program defined with Cornell-Gheskio a mechanism to improve the ability of its existing STD referral center (the locally perceived center of expertise) to conduct operations research relevant for nation-wide STD control, to promote training in comprehensive STD case management, and to provide counseling and education to patients infected with HIV. In this process, AIDSCAP reviewed Cornell-Gheskio's STD clinical and laboratory manual and recommended several revisions.

To learn more about STD care-seeking among CSWs, AIDSCAP developed a questionnaire for a survey of CSWs in Carrefour, as well as a questionnaire survey of clinicians working in that area. AIDSCAP also provided technical assistance for STD control in the Central Plateau through the NGO coalition headed by Save the Children, including field visits to develop a specific implementation plan, evaluation and training in clinical care, laboratory testing, quality control, and overall program management.

A highly successful condom social marketing program has sold almost 9 million condoms, and 67 percent of geographical areas in the country have access to sales outlets. The Haiti country program has been successful in heightening attention to correct condom use and encouraging individual risk assessment. Both males and females in the target populations have strengthened their awareness of the severity of AIDS and of their personal susceptibility. In a recent study, 90 percent could cite the heterosexual nature of AIDS transmission, name two correct modes of transmission, and recognize the CSM brand name, "Pantè."

One major breakthrough by AIDSCAP is the transfer to NGOs of the preventive approach and skills for the management of STDs. A partner notification system was successfully tested in an urban environment. Training has been key to the most important outputs of the USAID/AIDSCAP projects. All peer education and outreach workers, including health professionals and non-professionals, have required training and refresher courses. The AIDSCAP program has been instrumental in strengthening the NGO infrastructure to address the AIDS epidemic.

During the coming year AIDSCAP will focus on reaching adolescents and women, creating a supportive environment for behavior change through an intensive mass media approach, and expanding condom social marketing in rural areas. Also, with the prospect of political stability and the return of a constitutional government to power, new opportunities with the public sector will be identified. Training and educational materials development will be a primary need.

In summary, the AIDSCAP Haiti program, in the midst of serious economic and social problems, has succeeded in mobilizing a strong PVO/NGO community in the fight against STDs/HIV/AIDS. Their infrastructure has been strengthened and supported by training, technical assistance, and extensive distribution and sale of condoms reaching populations far beyond the urban and peri-urban centers. As a



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result of the program supported by USAID and AIDSCAP, many more people are aware of the need to take personal action to prevent HIV infection.

Haiti Process Indicator Data

Total People Educated	357,358
Males	70,750
Females	114,337
No Gender Specified	172,271
Total People Trained	3,811
Males	1,652
Females	1,229
No Gender Specified	930
Total Condoms Distributed	9,679,853
Free	865,201
Sold	8,814,652
Media Spots Aired	47,264
Total Materials Distributed	99,308

Haiti process indicator data in this table reflects most activity through September 1994 except for the following missing data: 23447 August - November 1993, January 1994, September 1994; 23448 December 1993, September 1994; 23449 January, June, and July 1993; 26452 April - July 1993; 26453 August 1994; 26046 September 1994.



Haiti Baseline Indicators⁽¹⁾

	High Risk		Low Risk ⁽²⁾	
	Males	Females	Males	Females
Syphilis prevalence	N/D	25	4-6	5-11
Knowledge of 2 preventive methods	N/D	76	35-82	35-83
Appropriate perception of risk	N/D	85	23-86	21-86
Condom use in high-risk situations	16	6-74	16-39	6-33
STD treatment according to national guidelines	79	79	79	79
2 or more sexual partners in last year	N/D	N/A	13-15	2-13
Talked with partner(s) about AIDS in last 3 months			68	83

Data expressed in percentages; ranges reflect multiple populations

N/A = Not applicable

N/D = Not available at time of report

(1) = Collected before or during initial stages of implementation of AIDSCAP program

(2) = Includes "youth/adolescent" populations



HONDURAS

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In February 1993 an AIDSCAP team visited Honduras to assist USAID/Tegucigalpa in the development of its strategy for HIV/AIDS prevention. In April 1994 AIDSCAP, USAID/Tegucigalpa, the MOH STD/AIDS Division and its counterparts in four health regions of Honduras developed a detailed implementation plan of assistance for the National STD/AIDS Prevention and Control Program. The plan forms the basis for the next two years of HIV/AIDS activities in the country. Interventions are planned for select target populations—people in the workplace, core groups, and the Garífuna population—in Tegucigalpa, Comayagua, San Pedro Sula, and La Ceiba.

The principal activities of the implementation plan are the following:

- Support STD programs, clinics and laboratories in (1) training medical and paramedical personnel, (2) selective purchasing of equipment, and (3) improvement of STD diagnosis and treatment
- Provide technical assistance and support for the development of BCC training and/or mass media materials that promote behavior change for the target populations based on quantitative and qualitative research
- Develop subprojects for people in the workplace through industrial associations, businesses and zonas industriales de producción (ZIPs)
- Provide technical and financial assistance to NGOs for HIV/AIDS/STD prevention work with high-risk groups
- Support policy dialogue at all levels to promote norms, laws, and policies that facilitate implementation of HIV/AIDS/STD prevention programs
- Develop workshops, conferences and seminars with the the commercial, industrial, community, and religious sectors to leverage greater support and resources for prevention programs
- Participate with the MOH, the Honduran Social Security Institute, donor agencies, and national and international organizations to assure the availability of a consistent and adequate supply of condoms for the selected target populations.

At present AIDSCAP is waiting for the USAID transfer of funds to begin work on the Honduras program.



AIDSCAP

JAMAICA

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Measuring 146 miles long and between 22 and 58 miles wide, Jamaica is the third largest of the Caribbean Islands and the largest of the English-speaking Caribbean Islands. The country has approximately 2.5 million people, with an annual population growth rate of 1.4 percent. Life expectancy is approximately 69.3 years for men and 72.7 years for women. The adult literacy rate is 75 percent. The per capita GNP in 1992 was USD 889. Jamaica's principal sources of income are services, manufacturing, construction, mining and quarrying, and agriculture, forestry, and fishing. Health expenditures for FY 92 were 3 percent of the GNP or USD 30 per capita (source: MOH).

In Jamaica the first case of HIV was diagnosed in 1982; as of June 1994, 831 cases of AIDS were reported. Sixty-four percent of reported cases are male. To date, 518 people have died of AIDS. The areas around Kingston and Montego Bay have reported the highest number of cases. The majority of cases are in the 30-39 year age group. Sexually transmitted disease rates are significantly higher than HIV rates. Currently, one out of every 30 STD clinic attenders is infected with HIV. The island's large tourism and commercial sex industry, high levels of alcohol and drug abuse, substantial number of migrant laborers, and high rates of sexually transmitted diseases suggest that HIV could spread rapidly among the general population.

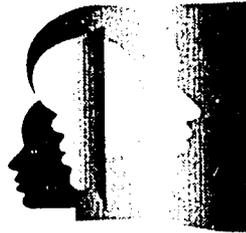
The USAID/AIDSCAP program has expanded previous USAID-funded HIV/AIDS prevention activities. In 1988 USAID initiated activities to address the growth in HIV/AIDS cases and dramatic increases in STDs. The USAID project was extended in 1992 and a stronger emphasis was placed on increasing access to condoms, reducing the number of partners, and improving the diagnosis and treatment of STDs. Additional resources from the Latin American and Caribbean Bureau were made available to support program activities.

The USAID/AIDSCAP program in Jamaica was designed in 1992. It focuses on STD patients, commercial sex workers, men who have sex with men, adolescents, people with multiple partners, and people who are HIV-positive. The program also focuses on intermediaries who can reach these target groups, including health workers, policy makers, opinion leaders, and retailers.

The USAID/AIDSCAP program is fully integrated with the National HIV/STD Control Program (NACP). The AIDSCAP country office is housed in the same building as the NACP and supports eight NACP staff positions as well as the majority of AIDS prevention activities. Activities are implemented by both public and private sector agencies, with increasing involvement of indigenous institutions to ensure sustainability beyond participation of the donor agencies.

In the two years since its launch, the USAID/AIDSCAP program has strengthened the NACP's capacity to develop strategies for target groups, instituted prevention outreach in urban and rural areas, and increased demand for condoms.

Interventions for improving the diagnosis and treatment of STDs have included both the public and private sectors. The Medical Association of Jamaica launched a six-part continuing education program for private physicians, the first effort of its kind.



AIDSCAP

The project is successfully reaching approximately half of the target audience of physicians in private practice. The training is also reaching physicians who work in the public sector.

Jamaica's 13 public STD clinics are being strengthened to provide better case management, and public health care workers are being trained in the use of national guidelines for management of STDs. The program has completed an algorithm validation assessment for women and modified the nationwide treatment guidelines based on results of this study. Laboratory technical assistants are being trained in syphilis testing, and contact investigators are being trained in better counseling and investigative and reporting skills. Syphilis screening is being decentralized to increase point-of-first-encounter diagnosis and treatment.

Behavior change communication interventions are guided by a comprehensive communication strategy that is based on findings from behavioral research data. The strategy defines target groups, outlines appropriate strategies and desired behavior changes, and describes corresponding messages.

The Face-to-Face Project launched a nationwide program to provide interpersonal education to complement the mass media campaign. Each of the 14 regions in Jamaica has a trained cadre of educators reaching adolescents and adults with multiple sexual partners. The extensive structure of the program enables the target groups to be reached even in isolated rural settings.

The Jamaica Red Cross/AIDSCAP Program has expanded its Kingston-based pilot project for in-school adolescents to include out-of-school youth in marginalized communities. Adolescents participate in 14 hours of behavior change activities.

The internationally acclaimed play, "VIBES in the World of Sexuality" is performed for adolescents in the above-mentioned projects as well as numerous other settings. VIBES promotes communication with parents, self-esteem, and knowledge about STDs, HIV and AIDS through drama. The musical drama creates a communication channel for adolescents and adults.

The Jamaica AIDS Support (JAS) project has successfully reached young men who have sex with men. Despite intolerance of and violence toward homosexuals, JAS has successfully created a safe atmosphere for these men to congregate and learn about safer sex practices. The project initiated activities in Kingston in 1992 and has now expanded to Montego Bay and Ocho Rios. The ACOSTRAD project initiated an intervention for CSWs in Kingston and expanded to Montego Bay. It has included testing for HIV and training of commercial sex workers to become peer counselors. ACOSTRAD has strengthened group support and education programs.

A local public relations firm, Berl Francis and Co., launched activities that keep STD/HIV/AIDS issues in the media. Newspapers, magazines, talk shows and radio stations are now regularly providing coverage of AIDS-related issues.



In the remaining two years of the project, the USAID/AIDSCAP program in Jamaica will consolidate its significant progress to date, develop additional sustainable projects, and focus on capacity building. The NACP's capacity to define the extent of the HIV/STD problem will be improved as sentinel surveillance is strengthened. The private sector will be targeted to launch AIDS-in-the workplace programs. Marginalized communities with a high incidence of STDs and HIV will be challenged to confront their own HIV/AIDS problems and develop a response that will influence sexual behavior. Access to condoms will be improved through identification of retail outlets in communities and launching an incentive program for distributors. A referral network for HIV-positive people will be established, drawing on the staff of social agencies across Jamaica. A mass media campaign will be launched using radio and TV spots as well as billboards.

Jamaica Process Indicator Data

Total People Educated	142,129
Males	44,879
Females	47,781
No Gender Specified	49,469
Total People Trained	812
Males	284
Females	293
No Gender Specified	235
Total Condoms Distributed	294,570
Free	294,570
Sold	0*
Media Spots Aired	65
Total Materials Distributed	159,354

Jamaica process indicator data in this table reflects activity through September 1994.

* 3 million+ condoms sold by private agency, promoted by AIDSCAP-supported SOMARC project, but attribution to AIDSCAP is not clear at this moment.



AIDSCAP

Jamaica Baseline Indicators⁽¹⁾

	High Risk		Low Risk ⁽²⁾	
	Males	Females	Males	Females
HIV prevalence	1.1-12.0	12.7	0-0.4	0.1-0.5
Syphilis prevalence	24	24-41	1.8	4.4
Knowledge of 2 preventive methods	26-66	17-34	26-71	17-70
Appropriate perception of risk	45-89	37-67	45-60	37-72
Condom use in high-risk situations	55-88	18-90	25-43	28-36
STD treatment according to national guidelines	44-60	44-60	44-60	44-60
2 or more sexual partners in last year	N/D	N/D	42	21

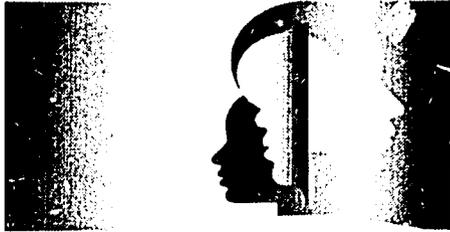
Data expressed in percentages; ranges reflect multiple populations

N/A = Not applicable

N/D = Not available at time of report

(1) = Collected before or during initial stages of implementation of AIDSCAP program

(2) = Includes "youth/adolescent" populations



AIDSCAP

ASSOCIATE

COUNTRIES

IN

LATIN AMERICA

AND

THE CARIBBEAN



AIDSCAP

BOLIVIA

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In October 1993 AIDSCAP fielded a team to conduct a mid-term evaluation of the USAID/Bolivia-supported HIV/AIDS/STD Prevention and Control Project. The evaluation team interviewed project staff, Mission personnel, staff of the former Secretariat of Health, and NGOs to assess the issues and challenges of each component of the project. General findings and recommendations were issued in the final report in order to maximize the remaining 15 months of the project.



AIDSCAP

COLOMBIA

III

USAID/Colombia and AIDSCAP supported a communication campaign aimed at increasing public awareness of HIV/AIDS. The campaign was conducted by the Colombian NGO, APOYEMONOS, and lasted from October 1992 to March 1993. Some of the activities of the project included the publication of 205,000 newspaper supplements, which contained HIV/AIDS-related articles and a condom, production of posters targeting high-risk groups and policy makers, and a Human Rights Day program intended to promote the rights of HIV-positive individuals and people with AIDS. It is estimated that over 16 million people were reached either directly by the campaign or indirectly by media coverage of campaign activities.

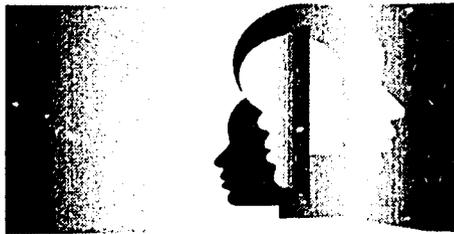


AIDSCAP

ECUADOR

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Two HIV/AIDS prevention subprojects were completed in Ecuador. The AIDS Prevention Pilot Program with High-risk Groups, an intervention executed by Fundación Futura, targeted populations at high risk for contracting HIV. Fundación Futura provided prevention communication through a network of peer health educators who promoted and marketed condoms among CSWs and their clients, brothel owners, and pharmacy workers. The second project, Ecuador National Program for Quality Assurance in HIV Testing, was a nationwide quality assurance program for laboratories implemented by the Ecuadorian Red Cross, the national reference laboratory for all HIV testing related to blood transfusions. The project established ongoing laboratory inspection and proficiency testing programs, improved data management and reporting capabilities, and trained laboratory inspectors in identifying laboratories' needs.



AIDSCAP

MEXICO

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AIDSCAP is supporting a project in Ciudad Juárez, Chihuahua, with the Mexican Federation of Private Health and Community Development Associations (FEMAP). FEMAP has trained peer health educators (PHEs) in six assembly factories and carried out weekly educational activities through the PHEs, who sell condoms after work hours at quitting time and in their home neighborhoods. Continuing education of PHEs is provided during monthly meetings. One factory experienced labor problems and FEMAP had to downscale activities, but many of the PHEs in this factory continue their educational activities. These include distribution of materials specific to the concerns of maquiladora workers, broadcasting of HIV/AIDS prevention cassettes in the workplace, one-on-one health education, and maintenance of a health advocacy network that covers a broad range of health and sexuality concerns in addition to HIV/AIDS/STD, such as family planning, improved relationships with spouses/partners, and job safety.



AIDSCAP

CENTRAL AMERICA

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COSTA RICA

AIDSCAP is supporting a one-year project to develop and test a curriculum and model project of prevention education for adolescents through the National Program for the Integral Attention of the Adolescent, conducted jointly by the Ministry of Health and the Social Security Institute. A curriculum has been developed and pretested, and training of trainers has been conducted in the three project sites: San José, Limón, and Puntarenas. Existing materials have been collected, reviewed, and selected for the program. Key participating institutions have been contacted to secure gatekeepers' support for the program. AIDSCAP provided technical assistance in the development of the curriculum.

OTHER CENTRAL AMERICAN COUNTRIES

The USAID missions in El Salvador, Nicaragua, and Guatemala have all requested and received support from AIDSCAP in the past year to conduct various technical assessments related to HIV/AIDS/STD. In May 1994 AIDSCAP fielded a team to conduct the HIV/AIDS/STD component of the USAID-supported health sector assessment in El Salvador. In September 1993 AIDSCAP responded to a request from USAID/Managua and assessed the National AIDS Control Program. And in August 1994, AIDSCAP provided a team to conduct a technical assessment at the request of USAID/Guatemala City.



Latin America and the Caribbean Process Indicator Data

	Mexico	Ecuador	Costa Rica
Total People Educated	2,112	4,446	0
Males	685	0	0
Females	1,427	0	0
No Gender Specified	0	4,446	0
Total People Trained	416	888	89
Males	103	0	27
Females	218	0	62
No Gender Specified	95	888	0
Total Condoms Sold	10,850	73,720	0
Total Materials Distributed	3,277	10,000	1,000

Mexico process indicator data in this table reflects most activity through September 1994 except for the following missing reports: 20052 March 1993, May 1994.

Ecuador process indicator data reflects activity through March 1994 for 20447. This project and 20446 closed as of July and September 1994, respectively.

Costa Rica process indicator data reflects activity through September 1994.



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TECHNICAL

AND

PROGRAMMATIC

ACCOMPLISHMENTS



MANAGEMENT

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With the completion of AIDSCAP's third year of its authorized five-year lifespan, the project has developed into a mature and fully-subscribed development program. Large-scale HIV prevention programs have been designed in 20 countries across three continents. Priority country programs are being actively implemented in 12 countries and are ready to start in two additional countries as soon as funding is received. The field-driven demand for AIDSCAP assistance has exceeded earlier design expectations, resulting in an expansive "associate country" program in 13 participating countries that ranges from large-scale country program design and implementation to smaller but long-term subproject activities to short-term technical assistance in program design and evaluation. Over 180 subprojects implemented primarily by indigenous nongovernmental and community-based organizations have been initiated to date and an additional 50 plus subprojects are anticipated to be launched in the coming year as the more recently designed country programs commence.

Supporting and assisting this level of activity requires an extensive, multi-leveled and well-coordinated management system. AIDSCAP has country offices currently functioning in eighteen countries and will be establishing additional offices in three more countries next year in response to newly launched programs in Honduras, Indonesia, and Morocco. AIDSCAP also has three fully-functioning regional offices—for Latin America and the Caribbean, Africa and Asia—each staffed with a full complement of highly skilled technical and management experts.

As the AIDSCAP project has grown, the demands on management have evolved and new challenges have emerged. Over the past year these included: (1) improving program effectiveness, (2) responding to AIDSCAP's conversion from a cooperative agreement to a contract, and (3) supporting special initiatives in response to the evolving epidemic.

IMPROVING EFFECTIVENESS

While the earlier years required a near total management focus on a myriad of start-up activities—country program design, staff hiring, and systems establishment—management efforts over the past year have begun to focus more intently on how to make AIDSCAP more effective, from the individual country programs to the overall multi-country project. Efforts to increase effectiveness have centered around four main strategies: decentralizing program management, strengthening capacity building, actively seeking feedback from the field, and disseminating lessons learned from the AIDSCAP experience to date.



Decentralizing Management

As AIDS CAP regional and country offices have become more established and experienced, efforts have been made to decentralize activities and authorities to the field. The design of new country programs, formerly coordinated by headquarters, has been decentralized to the regional offices and has been successfully implemented in countries such as Laos, Guatemala, and Zimbabwe. AIDS CAP's subagreement development process, its primary mechanism for subproject implementation at the field level, has been decentralized to support technical approval at the regional office level. While final financial approval of subagreements is still a headquarters function, some level of financial oversight is being allocated to the regional office. For example, over the past year AIDS CAP launched its country-level rapid-response NGO grants program and regional offices have the authority to technically and financially approve rapid-response grants.

Efforts to decentralize have been hampered somewhat by AIDS CAP's conversion over the past year from a cooperative agreement to a contract (see below). For example, AIDS CAP's previously decentralized process of allowing approval of local consultants at the country level had to be rescinded due to the new contractual requirement that all consultants be approved by the Washington-based contracts office technical representative.

It is expected, however, that over the course of the next two years additional responsibilities will be delegated to the field.

Capacity Building

Family Health International (FHI) has a long tradition of capacity building as the cornerstone of its development efforts. Under AIDS CAP, a special initiative is being undertaken to build on this tradition by formalizing these efforts and developing tools for measuring the impact of capacity-building efforts. As a first step to this effort, AIDS CAP has developed a capacity-building inventory tool to catalogue past efforts at the country level. This effort will be followed by a needs assessment of in-country implementing agencies, the development of training tools, and implementation of country-specific capacity-building strategies.

In addition, AIDS CAP has developed and is disseminating management tools for evaluation and information management systems for tracking subproject design and approval, planning technical assistance, and improving subproject budgeting.

AIDS CAP's MIS system continues to evolve in response to growth and change within the project. The system is comprised of a number of components resident in several different software programs on both the mainframe VAX system and the PC environment. The main VAX system currently functions primarily as a tracking and reporting system for financial and evaluation indicator data, with additional



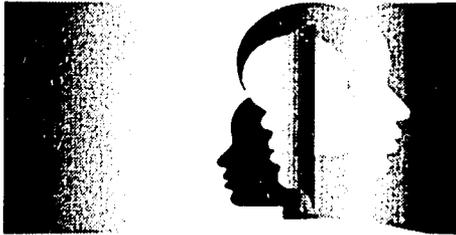
components slated for inclusion in the coming fiscal year. Other components of the entire MIS system monitor such project efforts and activities as the subproject development process, travel and technical assistance, and specific technical information and deliverables. Some of these components are to be integrated into the main VAX system directly, while others will remain discrete, but more explicitly linked to the VAX system with respect to key data fields and reporting processes.

Country Feedback

A key element to improving program effectiveness is regularly communicating with those who are closest to project implementation. Toward this end, AIDSCAP has undertaken two strategies: consultations of key staff and periodic program reviews. Regarding the first initiative, AIDSCAP has convened meetings of resident advisors on a regional basis, and evaluation and communication experts from across the project, including country, regional and headquarters levels. These consultations have typically lasted one week and provide an opportunity for staff to discuss common issues, identify solutions to common problems, be briefed on important program initiatives, and undertake combined and coordinated planning. Such meetings provide a cost-effective and efficient means of information sharing and team building and will be replicated as needed in the future.

AIDSCAP's program review strategy takes a complementary approach by sending a small delegation of AIDSCAP senior managers to individual country programs. The purpose of these reviews is to provide senior management with the opportunity to closely examine the country program, its progress, its relationships with host country counterparts and donors, and the continuing validity of the country plan. The program review also offers the chance for honest and direct dialogue between AIDSCAP senior managers, USAID Mission representatives, and a USAID Global Bureau HIV/AIDS representative to identify and resolve any issues that may be hindering optimal program effectiveness. Program reviews generally require nine days in-country for the team to visit and assess the progress of various subprojects and to discuss and address "special issues," which are sought from AIDSCAP staff across the project and USAID staff at all levels.

A formal report that records any proposed program revisions is disseminated quickly to AIDSCAP managers at the country office and regional and headquarters levels and to relevant USAID offices. To date, program reviews have been undertaken in five priority countries—Thailand, Brazil, Jamaica, Haiti, and Senegal—and are planned for the remaining priority countries over the next year. While reviews to date have generally confirmed the appropriateness of the country program in each country, one of the outcomes of past reviews has been the recognition of the need to increase the skeletal staffing levels in country offices.



AIDSCAP

Information Dissemination

The final area of management improvement has been the increased recognition of the need to more carefully chronicle AIDSCAP's lessons and progress, but also to put greater priority on disseminating the results of the project to the wider international AIDS prevention audience. Such dissemination has already been taking place through international AIDS conferences, participation in global consultations, and regular project reporting channels, including the establishment of AIDSCAP's project magazine, *AIDScaptions*. To this end, AIDSCAP is developing a comprehensive information dissemination strategy that will outline expanded opportunities for sharing information and the results of studies and lessons from subproject implementation.

CONTRACT CONVERSION

One of the major management efforts over the past year relates to establishing new procedures and systems to accommodate the change of AIDSCAP from a cooperative agreement to a contract. The conversion process required several months of discussion and development at USAID, during which all procurement actions were put on hold, preventing the obligation of funds to two priority country programs (Senegal and the Dominican Republic) and a large (\$750,000) buy-in for Morocco as an associate country program. The conversion has required a number of changes in the way AIDSCAP is perceived by Missions and in the management and operational systems of the project. For example, AIDSCAP is now precluded from discussing funding levels with Missions or providing critical input to Missions regarding the most appropriate scope of work given a proposed level of funding. Flexibility has been lost in the planning of country programs—flexibility that is frequently required given the difficulties in the field of implementing AIDS activities. Programmatic and financial reporting procedures have increased significantly. A series of "contract conversion memos" were disseminated across the project to provide guidance regarding new procedural requirements, and AIDSCAP's program management manual is being revised to incorporate the changes.

SPECIAL PROGRAM INITIATIVES

AIDSCAP's programs are generally designed in response to a specific country's needs based on a comprehensive needs assessment. Complementing this design approach, however, are a number of programs that emerge from specially identified or cross-cutting needs. These special programs can be categorized into two thematic areas: partnerships and responses to changing needs of the epidemic.



Partnerships

AIDSCAP works with a number of multinational, international, and bilateral organizations; however, two unique initiatives stand out: AIDSCAP's collaboration with UNICEF and AIDSCAP's PVO grants program.

UNICEF Collaboration in AIDS Prevention

UNICEF and AIDSCAP entered into a formal collaboration with the signing of a cooperative agreement on September 3, 1993. The purpose of this collaboration is to jointly apply the resources of Family Health International and UNICEF to amplify the impact of each organization's efforts in HIV/AIDS prevention. The nature of this collaboration is intentionally designed to be flexible to the needs of UNICEF's technical support groups and country offices. Current activities include FHI senior participation in two UNICEF technical support groups (sexual and reproductive health, and mass communication and mobilization); technical assistance in program evaluation; the development of an information support strategy under which a needs assessment of UNICEF's technical support groups was used to guide the development of an informational CD ROM; and technical assistance to the UNICEF/Cairo office to develop mass communication strategies for youth health and development.

AIDSCAP's PVO/NGO Programs

AIDSCAP manages two core-funded activities to support the participation of U.S.-based PVOs and indigenous NGOs in HIV prevention: a competitive PVO grants program and a rapid-response program.

The purpose of AIDSCAP's competitive PVO grants program is to strengthen the capabilities of developing country organizations to implement HIV/STD prevention programs. The objectives of the program are to (1) enhance HIV/AIDS prevention efforts by engaging the technical and administrative expertise of U.S.-based PVOs, (2) broaden the base of available technical expertise for HIV/AIDS prevention, and (3) foster collaboration between U.S.-based PVOs and local governmental and nongovernmental groups. Funding is provided from AIDSCAP core funds for multi-year grants up to \$400,000 over the life of the project. In keeping with standard USAID procedure, the PVOs are required to provide a 25 percent matching contribution.

To date, AIDSCAP has awarded nine PVO grants over three competitive rounds (one grant, to CARE International to work in Rwanda, was suspended after civil strife caused the closing of AIDSCAP's program). The grants are selected through a two-step review process that uses internal and external reviewers, involving the USAID Missions and the AIDSCAP resident advisors and regional office. Once the selected proposals are converted to subgrants, they are managed by the AIDSCAP



AIDSCAP

country office and become an integral part of the country program. Launching this program has been time- and staff-intensive; however, it has resulted in greater access by U.S. PVOs to funds for HIV/AIDS prevention. Over the course of the program it is clear that the capabilities of PVOs to design effective programs also has increased.

AIDSCAP's rapid-response mechanism provides AIDSCAP priority countries with up to \$20,000 per year to award small grants for community-based HIV prevention activities. Since the launch of this program in early 1994, over 80 grants have been awarded. These grants support a wide range of activities from special World AIDS Day efforts to community street theater and youth education programs.

Responses to the Changing Epidemic

AIDSCAP has introduced three major initiatives in response to the changing AIDS epidemic: the AIDSCAP's Women's Initiative, the Refugee/Displaced Persons Program, and AIDS Care and Management.

AIDSCAP's Women's Initiative (AWI)

Over the past few years AIDS prevention programs in many countries have been reporting that the rate of new infections is rising faster in women than in men. Often these women do not fall into traditionally considered "high-risk behavior" groups. They may be at risk due to the behavior of their partners or they may be at risk because they are in fact engaging in risky behavior through coercive or unavoidable behaviors. AIDSCAP realized, however, that it was becoming increasingly more important to reach women exposed to the threat of HIV who otherwise may not consider themselves at risk or may feel powerless to change their behavior. The purpose of this program is to maximize the impact of HIV/AIDS prevention programs on women in developing countries by integrating a broad approach for women in all AIDSCAP country programs, launching new activities at the community level, and collaborating on research and policy issues with other organizations.

To date the AWI program has established "focal points" in each regional AIDSCAP office, conducted dialogue with AIDSCAP resident advisors and implementing agencies to expand or introduce a women's component to ongoing AIDSCAP HIV prevention programs, developed action research protocols for studies on the female condom and the use of traditional birth attendants in AIDS care, and actively participated in the planning and conduct of a number of special confer-



ences. These have included organizing one of the few HIV/AIDS sessions at the International Conference of Population and Development in Cairo, participating in preparatory meetings to the 1995 Fourth World Conference on Women, and planning an "Asian Women and AIDS" conference for 1995.

Refugee/ Displaced Persons

In November 1993, AIDSCAP opened its Rwanda priority country program with the arrival of a resident advisor and the hiring of local staff. Soon after the opening of the office, the brewing civil strife boiled over with the downing of an airplane carrying the presidents of Rwanda and Burundi. Within a few weeks, AIDSCAP expatriate staff were evacuated and the entire USAID development program was suspended. As the killings escalated, a steady stream of refugees fleeing the violence grew into a torrent. By June over 350,000 Rwandans had migrated to the Kagera region of Tanzania. While these migrants were quickly settled into a large refugee camp, word began to spread that sexual activity was increasing, some of it by women for survival. Given the high seroprevalence rates inside Rwanda, it was apparent that the risk of HIV transmission was high and that prevention services were required.

AIDSCAP was asked by USAID Mission personnel in Washington to convene a meeting of possible partners to respond to the need for HIV prevention activities in the camps. Within two months of the first planning meeting on June 6, AIDSCAP had obtained USAID approval of a comprehensive HIV prevention program and had signed agreements with key implementing agencies. The partners include John Snow International (JSI) for baseline and follow-up program evaluation, Population Services International (PSI) for distribution and promotion of free condoms, and CARE International for behavior change communication and counseling and STD services. The CARE and JSI teams were in the field by August 6; the PSI project manager arrived in Benaco camp August 15.

This activity is the first of a multi-phased program. Subsequent phases will include (1) expanding the program to other refugee camps and planning for program continuation when refugees are repatriated to their country, and (2) developing an expanded program for international displaced persons.

AIDS Care and Management

While AIDSCAP's strategy is designed to address sexual prevention of HIV, it is also clear that in the most affected countries, to be responsive to the needs of communities and to maximize HIV prevention efforts at the community level it is critically important to address their needs for care. In acknowledgement of this



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need, AIDSCAP has introduced a pilot project to provide a quick-response mechanism for NGOs for innovative, community-based initiatives for care of people with AIDS and support of families affected by AIDS and AIDS orphans.

Six countries in Africa (Ethiopia, Kenya, Tanzania, Cameroon, Nigeria, and Senegal) and five in Latin America and the Caribbean (Brazil, Jamaica, Haiti, Honduras, and the Dominican Republic) will be eligible to participate in the small grants program with the concurrence of the USAID Mission in each country. Up to \$50,000 per year will be provided to each of these countries for award of grants up to \$20,000 per year. The competitive selection process will be determined at country level in response to local situations. To date, three grants have been approved for Haiti.



BEHAVIOR CHANGE COMMUNICATION

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Behavior change communication (BCC) is an important component of 92 AIDSCAP subprojects in 19 countries in three regions. Behavior change communication programs address a diverse range of target audiences including: commercial sex workers and their clients, men away from home, women and men in the workplace, truck drivers, youth and adolescents, refugees, men who have sex with men, street children, health professionals, STD patients, members of the armed forces, and people who are HIV positive. Altogether, 72 nongovernmental organizations and private voluntary organizations are involved in the implementation of AIDSCAP BCC-focused programs.

Technical aspects of BCC programs are overseen by a team of 11 communication officers and information, education, communication (IEC) specialists in all three regions and at headquarters. Several of these staff members are seconded from two of the three AIDSCAP BCC subcontractors: Ogilvy Adams & Rinehart (OA&R) (one communication officer at AIDSCAP Headquarters) and the Program for Appropriate Technology in Health (PATH) (five communication officers in three regional offices). In addition, staff from the three subcontractors (PATH, OA&R, and Prospect Associates) and local (in-country) communication specialists frequently provide technical assistance both at AIDSCAP headquarters (HQ) and in the field. This summer an associate director was hired for the BCC Unit at HQ; she will assume her duties November 1, 1994. These communication professionals have a wide range of expertise in counseling, peer education, training, mass media, small media, capacity building, and curriculum design.

APPLYING THE BCC STRATEGY

BCC programs are developed to meet the needs of specific and often hard-to-reach populations and target audiences, using a variety of communication media. These include people practicing high-risk behavior, such as:

Commercial sex workers and their clients

All AIDSCAP priority countries include outreach and/or peer education programs. For example, the Centre de Orientación Investigación Integral (COIN) in the Dominican Republic has developed a peer education strategy with the full participation of CSWs in research, design, and planning. In Haiti, IMPACT reaches clients of CSWs by using tap-tap drivers (local taxi/buses) as peer educators who play behavior change messages on audiotapes for their riders.

Sexually transmitted disease patients

STD patients are reached through clinics in most priority countries. Technical assistance in curriculum design and materials development is being provided in Thailand by PATH, and throughout the AIDSCAP project.



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Men and women away from home (e.g., truck drivers, traders, military, migrant workers)

BCC programs that target men and women away from home exist in many AIDSCAP countries. Examples include programs in the Asian areas of affinity along the Thai border, in South Africa with mine workers, and in Cameroon with the military.

Other target audiences for BCC programming include individuals whose partners are at high risk of infection, such as:

Women whose partners have multiple partners

In Kenya, for example, BCC interventions are integrated into HIV/STD programs at family planning clinics and are able to reach women whose partners have several sex partners.

Adolescents, especially girls and young women

A rural project in Haiti targets girls and young women (being poor, being a woman, and coming from a rural area are among the major risk factors for HIV in Haiti) through rural health clinics, women's centers, and traditional healers. Students are targeted in nearly all priority countries. Youth out of school are targeted in Haiti (through sports events) and in Ethiopia and Brazil through projects designed to reach street children.

Sexually active individuals in high HIV prevalence areas

Individuals are targeted according to: their (high-seroprevalence) geographic location as in Bangkok, Thailand; in their workplace, as in Nigeria, Tanzania, Kenya, Haiti, and Brazil; or through community-based interventions, as in Haiti, Brazil, Cameroon, Nigeria, Tanzania, and Thailand.

Communication media utilized throughout the AIDSCAP project varies greatly. Interpersonal communication (outreach, peer education, individual counseling or group counseling) and small media (locally produced printed materials) are incorporated into the majority of BCC interventions. However, other channels, including educ-entertainment (theater, music, special events) and the distribution of videos, such as "The Faces of AIDS," have proven to be very powerful. Mass media (radio, television, newspapers) is used to some degree in nearly all AIDSCAP priority countries. Examples can be found in Senegal, Nigeria, Kenya, Tanzania, Haiti, Jamaica, the Dominican Republic, and Thailand.

Institutional strengthening of communications skills and training skills for HIV/AIDS prevention is a major AIDSCAP strategy for implementation of effective and sustainable programs. This includes the support of programs that focus on effective communication strategies for change in risk behavior and the social norms that support this behavior. In addition, training is a prerequisite to effective prevention programs because it ensures a mechanism for setting standards and for human resource capacity building.

Capacity-building activities have been implemented in all three regions and at HQ since the inception of the project. An excellent example of the scope of AIDSCAP



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capacity-building work can be seen in Kenya, where PATH is providing training on the process of effective media and BCC materials development to members of the NGO AIDS Consortium. This training is being accomplished through a series of two- and three-day workshops, conducted at one- and two-month intervals to allow participants to practice the skills learned at each workshop. The ultimate goal of this particular project is to strengthen the capacity of Kenyan institutions to carry out AIDS prevention activities by institutionalizing BCC media and materials development skills among program staff of member agencies of the NGO AIDS Consortium. To achieve these goals, consortium members are learning to conduct and evaluate focus group discussions, create focus group guides, and "transform" research data into message design and materials development.

Another example of successful capacity building occurred in Thailand where a workshop, *Reporting on HIV/AIDS: Facing the Facts*, was held on March 20-25, 1994, and was attended by eighteen journalists from nine countries. This workshop was a collaboration between the Information Programs and BCC units at AIDSCAP HQ, and BCC staff from the Asia Regional Office.

"The Faces of AIDS," an AIDSTECH/AIDSCAP film that tells the story of the human experience of living with AIDS in Africa, continues to be disseminated through Media for Development International (MFDI) and AIDSCAP HQ. The 20-minute documentary is available in English and French and, as of this year, Swahili and Vietnamese. Accompanying materials for the video include: a flyer and discussion guidelines available in English, French, and Swahili, and Broadcasters Guidelines in English and French. "The Faces of AIDS" Swahili version also comes with a seven-minute, Swahili-language music video of Philly Lutaaya's "Alone and Frightened," performed by the Kenyan group, *Musically Speaking*. It is estimated that a total of 1,750 copies have been distributed through gifts, sales, and loans.

A report of the feedback from the first year of release of the AIDSTECH/AIDSCAP-financed "The Faces of AIDS" video was prepared for AIDSCAP by the distributors, Media for Development International (MFDI). With support from AIDSCAP, MFDI instituted two mechanisms for the collection of data to evaluate the impact of "The Faces of AIDS": special evaluation screenings (to assess the impact of the film on target audiences, encourage the use and distribution of the film and learn how the film can best be put to use in the African context); and evaluation forms distributed with the videos (to discover what had been either heard or learned from the showings in their specific geographic areas). MFDI also entered the video into several competitive festivals, and it won awards from the British Medical Association and the Black Filmmakers Hall of Fame. BCC HQ maintains files of BCC materials and responds to requests from AIDSCAP staff and NGOs for other relevant materials developed in the field. BCC Unit staff are currently in the process of developing an IEC database for materials developed through the AIDSCAP project.



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The AIDSCAP Communication Officers Consultation (COC), held July 12 to 14, 1994, presented an opportunity, midway through the AIDSCAP project, for AIDSCAP's global communication staff and subcontractors to review the accomplishments of the past, revisit the current behavior change communication strategy, and set goals for the future. The COC was attended by BCC headquarters, regional, and country staff, as well as communication experts from four AIDSCAP subcontractors: Ogilvy Adams & Rinehart, PATH, Prospect Associates, and the Center for AIDS Prevention Studies, UCSF (CAPS). In addition, colleagues from USAID and other technical program areas of AIDSCAP added their expertise to the proceedings. One outcome of the COC was a revision of the BCC technical strategy, which will strengthen AIDSCAP's ability to design interventions that follow certain strategic guidelines and theoretical approaches.

A review of AIDSCAP mass media activities was completed by the BCC Unit this past year. The review found that, generally, mass media activities had not been incorporated into strategic and implementation planning as part of a comprehensive communication plan because there has been a perception that mass media projects are expensive and are not able to target specific audiences. The review asserts, however, that mass media efforts are essential at different stages of the behavior change continuum to reinforce other communication media and can be accomplished for less money than previously expected.

In addition to the mass media review, FY 94 also saw a review of HIV/AIDS materials inherited by AIDSCAP from the AIDSTECH project. The purpose was to examine the materials for: quality, response from the field, technical soundness, conformity with the AIDSCAP mandate, potential need for accompanying materials, and potential costs and mechanisms for funding and further distribution. In the past two years 1,151 copies of *Emma Says: Each Time, Every Time*, 1,273 copies of the *STD/AIDS Peer Educator Training Manual*, 1,605 copies of *The Illustrated Peer Educator Workbook: A Guide to Preventing STDs and AIDS*, and 1,610 copies of the *AIDS/STD Education and Counseling Manual* were distributed. All of these materials are available in both French and English.

Because of the high demand for these materials, additional copies of selected manuals were reprinted in the fall of 1994. In addition, AIDSCAP was requested to share the original proofs of these manuals with several NGOs who wished to adapt and reprint the manuals themselves.

In August 1993 a five-person team conducted an assessment of counseling services in Benin, Burkina Faso, Guinea, and Mali at the request of USAID/REDSO. The purpose of this travel was to: assess the current types and status of counseling services funded by donors who sent participants to a June 1989 counseling workshop; assess strengths and weaknesses in public and private sector HIV/AIDS counseling programs; determine the extent to which the 1989 workshop objectives had been achieved; summarize lessons learned and recommend future steps for improving counseling programs in West Africa; and identify preliminary, relevant



indicators for evaluating counseling services and activities in the African setting.

As a result of the initial team's findings, USAID/REDSO requested that the team leader and a consultant return to West Africa in September 1994 to further explore the Guinean counseling experience and recommend future steps for improving counseling programs in West Africa. A report of these findings will be available at the end of 1994.

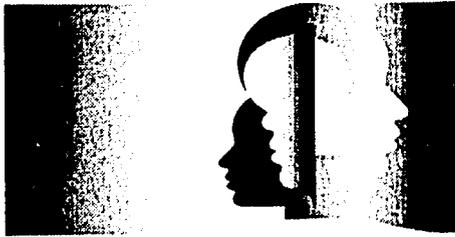
AIDSCAP's BCC and STD units are collaborating in the development and testing of the targeted intervention research tool, which is designed to assist program managers in understanding a community's perspective on sexually transmitted illnesses and STD services, describe determinants of local perceptions of STDs and AIDS, and enhance treatment-seeking behavior. In addition, a concept paper for the integration of BCC activities with STD interventions is currently being developed. This paper will address STD health-seeking behavior, treatment compliance, condom use, partner notification, and providers' counseling skills.

The BCC unit is also developing a training guide for the Private Sector AIDS Policy Presentation (PSAPP) project and a video for motivating business leaders to implement HIV/AIDS workplace programs.

ISSUES AND IMPLICATIONS FOR THE FUTURE

Behavior change communication experts face many challenges when forced to balance between effective programming, budget availability, and political forces. The following is a list of several of the more pressing issues faced by the AIDSCAP program today.

- 1) It is still difficult to speak openly about sexual education in many countries, even those most affected by the epidemic. These "moral" barriers prevent the creation of programs that speak directly to youth about sexuality, despite the fact that most project planners and NACPs recognize that preventing HIV infection among youth should be a priority. In addition, accessing all youth, including those who are not in school, is challenging but essential to effective programming.
- 2) Women are the most vulnerable group at risk of HIV infection. Behavior change in this group is unlikely to occur without improvement in the education, employment opportunities, and/or social status of women. Also, many women are at risk of HIV infection through the behavior of their regular sexual partners. Because of this dual risk, changing men's attitudes is as important as improving women's status, and BCC programs need to target both partners.
- 3) Moving implementing agencies and ministries of health from traditional "health education" approaches to AIDSCAP's behavior change approach is



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challenging, as is the incorporation of sufficient operations research into BCC programming to inform decision-making processes.

- 4) AIDSCAP is under constant pressure to address the entire "general population" of a country, as opposed to selected target audiences. However, experience has shown that working at the epicenter of the epidemic (with high-risk groups) is more cost-effective. It is also evident that there is still a need for continuing diffusion of information about HIV/AIDS to the general population. AIDSCAP programs address both of these issues.
- 5) Many countries lack the indigenous resources in public relations needed to target community, political, and religious leaders. The support of these leaders is often a prerequisite to successful communication programs.

The future of successful HIV/AIDS prevention programs will depend upon the effective use of behavior change communication interventions. Several of the most pressing needs are listed below.

- 1) Behavior change communication must remain a priority among the prevention strategies, especially with the recognition among scientists that a vaccine against HIV is not expected in the near future.
- 2) Programs that target vulnerable groups, such as youth and women, must be intensified. However, programs should take into account that men, in most instances, are the decision makers and should be targeted more aggressively.
- 3) In order to achieve sustainable interventions there is a need for continuing and strengthening communication and behavior change capacity building within NGOs.
- 4) Identifying and training community leaders is crucial to maximize both the diffusion process and behavior change across a community and promote social change in systems, as well as in individuals.



BEHAVIORAL RESEARCH

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One of the most useful lessons learned during the first decade of AIDS prevention is the importance of behavioral research. This research has given us a better understanding of why people engage in behavior that places them at risk of HIV infection and has revealed promising approaches for changing that behavior.

Knowledge of the basic facts about AIDS is not sufficient to change behavior. For behavior modification to occur, individuals need to understand what constitutes high-risk behavior and recognize their individual risk and vulnerability, as well as the severity of the consequences of risk-related sexual behavior. In addition to imparting the benefits of low-risk behavior, prevention programs need to provide the skills required to practice safer sex.

Interventions must also be sustained in order to maintain desired changes in behavior. Therefore, one needs to address community and societal factors, policies, and structural issues that influence and shape behavior. Community and societal factors include social pressures and cultural expectations for risk-taking sexual behavior, lack of skills in sexual negotiation, and gender discrimination. All of these lessons form the basis of AIDSCAP's approach to behavioral research activities. The Behavioral Research Unit (BRU) at AIDSCAP is comprised of three senior researchers, two program assistants, and a staff assistant. The primary subcontractor to the BRU is the Center for AIDS Prevention Studies (CAPS) at the University of California at San Francisco.

Beginning in April 1993, the BRU was also the base for a women and AIDS research officer through funding made available from USAID's Women in Development office. This staff member, the only one in AIDSCAP specifically responsible for gender issues, successfully evaluated several AIDSCAP projects for their focus on women, while fulfilling the role of liaison on the issue of women and AIDS between units, country and regional offices, and AIDSCAP and other organizations. She subsequently developed a strategy paper, outlining the policy and future directions for AIDSCAP's units and country programs. In April 1994 this strategy became the basis for the AIDSCAP Women's Initiative, which has become an autonomous unit within the Office of the Director.

The goal of the behavior research program is to gain scientific understanding of high-risk behaviors associated with the transmission of HIV/AIDS, the determinants and contexts of these behaviors, and methods for their modification. With this knowledge, AIDSCAP will contribute to ongoing prevention strategies worldwide.



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**APPLYING THE
BEHAVIORAL
RESEARCH
STRATEGY**

The social and behavioral research conducted by the unit is designed to meet six objectives: (1) to explore the meanings, contexts, and determinants of sexual behavior that places people at risk, the process of behavior change, and methods for modifying sexual behavior; (2) to understand patterns of partner exchange; (3) to test and analyze new behavior change interventions such as counseling and testing, their efficacy in producing changes in sexual behavior, condom use, and reduction of sexually transmitted diseases (STDs), and the acceptability and sustainability of such interventions; (4) to improve STD recognition and describe health-seeking and provider behaviors; (5) to understand the social and biomedical factors that influence the impact of AIDS on women and the effect of interventions; and (6) to support the capacity of developing country social scientists and institutions in priority countries to conduct AIDS behavioral research.

In 1992 AIDSCAP assumed responsibility for projects that were initiated in September 1990 under the AIDSTECH cooperative agreement, referred to as the AIDS Behavioral Research Grants Program. This program was a collaborative project undertaken by the U.S. Agency for International Development through Family Health International (FHI), the National Center for Nursing Research, the National Institute of Child Health and Human Development, and the National Institute of Aging, with communications coordinated by FHI.

Responsibility for monitoring these projects is shared among the donors. FHI has been monitoring four of these studies in Haiti, Uganda, Indonesia, and Jamaica, with the latter two recently completed. An intervention study is also funded in Indonesia under AIDSCAP, in which the information obtained from the earlier phase of research serves to develop and assess brothel-based interventions to distribute condoms and promote safer sex. Five research fellows have also been supported under the AIDSTECH cooperative agreement. The countries selected for study in AIDSCAP Behavioral Research Grants Program are characterized by different levels of HIV prevalence. In all of the countries, HIV is increasing among heterosexuals, and prevention efforts are hampered by a relative lack of knowledge regarding the modes of transmission, infrequent condom use, and misperceptions of personal risk and susceptibility to AIDS.

To improve strategies that change sexual behaviors, AIDSCAP has supported a collaborative research project undertaken by the University of the West Indies in Kingston and the University of California at Los Angeles to examine social and cultural factors that influence the sexual behavior of high-risk groups in Jamaica. The study of a random sample of approximately 2,500 men and women age 15 to 50 concluded that although most of the respondents were in "visiting" relationships, most also held traditional values on marriage, family, and children. The context of relationships, rather than the level of sexual and HIV-related knowledge, appeared to be the determinants of high rates of pregnancy, rates of partner exchange, and condom use. Factors that increased sexual risk-taking centered on high rates of unemployment and women's economic dependence on men. Even though men were more likely than women to report that their condom use had



increased over the past year, women were more willing to endorse greater condom use to avoid disease.

Other studies funded by AIDSTECH emphasized the level of AIDS knowledge and awareness and obstacles to condom use. The University of Michigan and Udayana University in Bali have completed a study investigating the sexual practices and condom use for HIV prevention among several groups of sex workers and their clients in Bali, Indonesia. Several distinct groups of sex workers exist in Bali, with differing levels of AIDS and STD knowledge, risk behaviors, and programmatic needs. Among the Indonesian women who have mainly local Indonesian clients, condom use, AIDS knowledge, and understanding of other STDs and their appropriate treatment is very poor.

The data collected in Bali have been used to design an ongoing intervention in female sex worker complexes in the Sanur and Charik area near Denpasar. The objectives of the intervention are to develop and evaluate a program to increase community knowledge and awareness among low-price female sex workers and clients regarding STDs, including AIDS, and increase condom use among female sex workers and their clients. The study also seeks to investigate the effects of both contextual and individual variables on condom use among both groups.

Studies funded under the AIDSCAP Thematic Grants Program advance the scientific understanding of risk behaviors and methods of modifying those risk behaviors for HIV/AIDS prevention through large-scale multi-year research awards. All research grants must receive approval for funding based on reviews conducted by a technical working group and program committee to evaluate their scientific merit and policy relevance. Preference is given to proposals from institutions in developing countries or those that reflect a collaboration between institutions from developing and developed countries. AIDSCAP works closely with investigators in project design, implementation, and the dissemination of research results.

For instance, a study currently underway by Johns Hopkins University and Chiang Mai University in Chiang Mai, Thailand, employs both qualitative and quantitative research methodologies. The study includes qualitative research on sexual decision making and practices among both men and women at high risk for HIV infection; quantitative behavioral and epidemiologic investigations of sexual behavior and HIV risk reduction strategies; and controlled interventions to reduce the risks of heterosexual transmission of HIV in Northern Thai adolescents and young adults age 15 to 35.

An additional mechanism to achieve AIDSCAP's research objectives is program-related research, which allows investigators, in close collaboration with country programs, to test innovative approaches and respond to identified research needs through a small number of small-scale pilot studies or larger grants that develop and test interventions. This research aims to contribute to the design, implementation, and evaluation of specific interventions, focusing not so much on impact but



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rather identifying under what conditions interventions work best. Resources are focused in areas closely linked to AIDSCAP's programmatic interests.

An example of program-related research is the Targeted Intervention Research (TIR) Study, which is being conducted in collaboration with the STD and behavior change communication units. A standard protocol has been developed to explore local knowledge and health-seeking behavior for STDs. The protocol is presently being field tested in Ethiopia and Senegal.

AIDSCAP commissioned research identifies factors related to high-risk behaviors in a given situation, mounts field studies of methods for modifying those factors, and investigates interventions linked to specific situations, that might be adapted later to other locales. Two commissioned studies are underway in Brazil as a collaborative effort between the Center for AIDS Prevention Studies (CAPS) and Brazilian researchers. The first study is being conducted in the city of Santos, in collaboration with the Municipal Health Department, where the sexual behavior, condom use, and exposure to STDs of a cohort of 400 dock workers are the focus of the investigation. Results to date show that 97 percent of the men in the sample have a primary partner, but 24 percent are either non-monogamous and do not use condoms consistently or are single and do not use condoms consistently. Five percent of the sample have sex with other men, and 22 percent reported STD symptoms or STD diagnoses during the previous year. Although the current level of infection in the sample is only one percent, there is clearly sufficient sexual risk to support the ongoing spread of HIV within the population.

The second study, developed by the Núcleo de Estudos para a Prevenção da AIDS of the Universidade de São Paulo, will evaluate an intervention aimed at night school student ages 18 to 25, who live in a high AIDS incidence area in the city of São Paulo. A wait-list control group design will be used in which four schools will be randomized. Students from two schools will receive interventions, and students from the other two schools will be the wait-list controls.

To date, a random sample of 483 night school students, stratified by age and gender, have completed a self-administered questionnaire. Their responses indicate that females rely more on monogamy than do males as a preventive strategy. Females also decide less frequently when and how to have sex and are less likely to perceive themselves as vulnerable to HIV infection and to believe that condoms are effective. These and other preliminary findings suggest that interventions should develop gender-sensitive approaches to address gender norms for men and women that may pose obstacles to safer sex.

Another commissioned study is the HIV Counseling and Testing Efficacy Study (C&T) being conducted by the BRU in collaboration with the World Health Organization/Global Programme on AIDS (GPA). CAPS will serve as the coordinating center for the study. AIDSCAP will implement the study in Tanzania and Kenya, and GPA will conduct it in two additional sites, China and Trinidad.



A protocol development workshop for the C&T Study was held in September 1994. At this workshop, the principal investigators and personnel from AIDSCAP, CAPS, and GPA discussed and refined the site-specific protocols. The draft protocols will be developed, reviewed, and field tested in each counseling center site to determine their utility and identify areas that need refinement. As the C&T study is implemented, the coordinating center will work closely with the counseling centers at each site in the development, pilot testing, training, and quality assurance functions of the interventions.

The C&T Study was developed because voluntary HIV counseling and testing programs are now a major component of AIDS control programs in industrialized countries and increasingly are being implemented in developing country settings. Although it is generally accepted that voluntary counseling and testing can be of benefit in the care and support of individuals, research findings to date have been inconsistent on the impact of counseling and testing on risk behaviors. From the proposed study, the Behavioral Research Unit hopes to gain data on the efficacy and side-effects of counseling and testing; a profile of persons seeking these services; data on cost-effectiveness and the potential for cost-recovery; and patterns of risk-related behaviors, STD incidence, and their correlates. AIDSCAP and USAID believe that the proposed multicenter study will provide information on the potential contribution of counseling and testing programs to behavior change and will serve to guide public health practice and policy.

For several months during 1994 a behavioral research advisor was based in the AIDSCAP office in Kigali, Rwanda, to initiate and oversee behavioral research there. He was evacuated during the civil disturbances in Spring 1994.

**ISSUES AND
IMPLICATIONS
FOR THE
FUTURE**

The BRU has identified additional areas of research that will require emphasis in the future. Concept papers that serve to identify some of the research questions are currently being developed. Areas of research include the integration of HIV/AIDS into family planning programs; preventing HIV transmission in stable relationships; and structural and environmental determinants of risk and ways of modifying risk. Future concept papers and research protocols will be developed on research-based programs to prevent HIV infection in adolescents; testing community interventions; and behavioral research to answer policy questions. A brief description of the three themes that will be explored in the immediate future are discussed below.

The integration of HIV/AIDS into family planning is a significant emerging area for research and intervention. A clear rationale exists for the integration of HIV/AIDS into family planning programs. An estimated 6 million women are currently infected with HIV, and epidemiologic data demonstrate that women of reproductive age and their children are increasingly at greater risk for infection. Family



planning clinics are a suitable site for HIV/STD prevention efforts because many clients are vulnerable women of reproductive age. Family planning services are at times the only health care sought by women, and family planning workers are already experienced in discussions of contraceptive use and the promotion of behavior change. However, the level of integration deemed most advantageous should depend upon the epidemiologic data on HIV infection rates in the area served by the program. The resources available in family planning centers and the available support and interest on the part of clients, providers, and the community also need to be considered.

Preventing HIV transmission in stable relationships is the second theme to be prioritized in the time remaining to the AIDS CAP program. The AIDS epidemic has introduced a new hazard to sexual activity — any act of sexual intercourse now poses the threat of HIV infection. Fortunately, the probability of transmission is still low in most circumstances. Most prevention programs have accordingly emphasized certain behaviors as posing a particular risk of infection, such as having numerous sexual partners. By default, if not intentionally, these programs have also promoted less risky behaviors, such as keeping to a single sexual partner (of unknown serostatus). However, there is increasing recognition that sex with a stable partner may carry a significant risk of HIV transmission if the partner has been infected or if s/he is exposed to the virus through other sexual contacts or another route.

Recognition of the structural and environmental determinants of risk and ways of modifying risk is becoming increasingly important. HIV prevention to date has primarily used a psychological approach, attempting to persuade people to change behavior that places them at risk for infection. This is true even though it is well documented that certain structural and environmental factors, such as brothel-based prostitution, alcohol use, poverty, family disruption, and migration, are highly correlated with HIV incidence. There may be natural limits in the ability of individual prevention programs to promote behavior change. Enhancing the behavioral approach with changes in the social environment could significantly accelerate reduction of HIV incidence within many populations and geographic areas.

Any additional research projects yet to be initiated will be rapid so that information can be provided quickly to AIDS prevention programs, and theory-based, so that valid and pragmatic theories of behavior change may be used to guide activities in disparate locations and populations. They must be program-related to ensure that AIDS CAP's programs receive the most up-to-date behavioral research results and local support is available for the projects. Finally, they must be future-oriented, so that topics will interest developing country investigators and will respond quickly to future AIDS prevention needs, and creative, so that effective intervention strategies may be tested and identified.



CONDOM PROGRAMMING AND LOGISTICS MANAGEMENT

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AIDSCAP's Condom Programming and Logistics Management Unit is supported by two subcontractors, Population Services International (PSI) for condom social marketing (CSM), and John Snow, Inc. (JSI), for condom logistics. The condom unit consists of two staff members at AIDSCAP headquarters, as well as three regional staff members and seven country representatives.

A key measure in assessing the accomplishments of AIDSCAP's efforts in condom programming, condoms delivered by AIDSCAP's implementing partners, continues to increase. During 1993 AIDSCAP projects delivered 19.4 million condoms, both sold and distributed free. The corresponding figure for 1994 is 24.6 million, an increase of 27 percent. The life-of-project figure has increased to 65 million. Overall, USAID has provided some 62 percent of these condoms, while other donors, principally DKT International, have provided the balance.

Seventeen countries are receiving assistance in condom programming from AIDSCAP. As might be expected, the highest distribution figures come from the largest countries, such as Brazil, Ethiopia, and Cameroon. At the same time, both Haiti and Nepal account for substantial proportions of the total distribution, despite their relatively small populations.

There are interesting issues and obstacles in each of the country programs that have considerable influence on their ability to show progress. To illustrate the factors AIDSCAP is facing, a brief discussion of these in Brazil follows.

Brazil's progress in condom social marketing is impressive, with about 13 million condoms sold since the start of the project. Condoms are provided by DKT International, which uses its own resources to procure supplies for the project, and then is able to wholesale the product at a price that is high enough to finance the reorders. However, this means that the rate at which the volume can be increased is limited by the availability of DKT's capital. Sales have been constrained by this limit on supplies and by the testing procedures required by the Government of Brazil.

AIDSCAP has provided assistance to the state and federal governments to facilitate public sector distribution, and this is expected to increase the supply of free condoms. First, AIDSCAP has helped in laying the groundwork for the substantial World Bank loan, and, second, in improving the capacity of the government to handle and account for large shipments of condoms (as well as other medical supplies, including those relating to AIDS and STD treatment).

AIDSCAP has been intensively involved in an effort to enable the central and state governments to receive, store, ship, distribute, and account for AIDS prevention and treatment supplies, no matter what their source. AIDSCAP assisted in rejuvenating interest in establishing real logistics management in the national AIDS program, and designed essentially from scratch a vertical system under the control of the federal and state AIDS officials, bypassing the old system in which no confidence remained. During FY94 the following were accomplished:



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- Developed logistics management curricula with state and federal officials and 120 Ministry of Health and NGO personnel and 10 counterparts in logistics management
- Established a vertical warehousing system in Rio de Janeiro and São Paulo states
- Sponsored a logistics coordinator for São Paulo through JSI/FPLM's logistics management training
- Provided technical assistance for the storage and distribution of 7 million USAID condoms, helping to ensure free condom supplies for NGOs associated with AIDSCAP
- Prepared condom and STD pharmaceutical forecasts for Rio and São Paulo states
- Implemented a national essential commodities management information system in Brasilia, São Paulo, and Rio de Janeiro
- Developed and initiated the use of a national logistics management information system data collection form.

In addition to providing technical assistance to various country programs, the condom unit produces a monthly report on condom distribution with updated information on current, year-to-date, and life-of-project sales and free distribution, broken down by country and by subagreement. A global condom requirements forecast was developed for the USAID Office of Health for both public and private sectors. Based largely on JSI/Family Planning Logistics Management's (FPLM) contraceptive procurement database and PSI's market information, this forecast probably represents the best information available for AIDSCAP countries' realistic need for condom supplies.

AIDSCAP, with assistance from JSI/FPLM, produced an in-house logistics training workshop in which over 30 AIDSCAP personnel were introduced to the demands of logistics management through a simulation of five-year cycles of forecasting, procurement, storing, shipping, distribution, and reordering in a fictitious country.

**ISSUES AND
IMPLICATIONS
FOR THE FUTURE**

Several issues, recognized at the beginning of the project, continue to have an impact on AIDSCAP's ability to ensure quality condom programming:

Availability of stocks

AIDSCAP continues to be dependent on condom stocks provided by collaborating agencies, be they private (DKT) or public (USAID).



The Emergency Fund established by the USAID Office of Health is helpful for special situations, such as in Ethiopia where help was needed to bridge a gap between outside supply —largely from UNFPA through PSI - and Mission funding. But the fund is severely limited in size and is not meant to finance large stocks of condoms over time.

Part of the rationale for allowing AIDSCAP to source its own condoms was the expectation that other donors would become more involved in the AIDS epidemic. While there are some exceptions, it is generally the case that other donors have not come forward.

Limited information

Projecting both country-level and project-wide condom needs (as well as those for STD drugs) depends upon information specific to the situation. Condom requirements derived from demographic and epidemiological information are suspect for several reasons, but fundamentally they are estimates of how many condoms a population "ought" to use. They are not based on an appraisal of the various systems' capacities to deliver condoms and typically do not represent effective demand.

AIDSCAP has designed a "condom audit" that would more accurately reflect the conditions condom programming would face in a given country, thus providing more realistic projections of commodity requirements.

Limitations on logistics activities

The activities in Brazil described above are unique to that country. AIDSCAP has not been able to finance such activities in other countries. On the other hand, there is a severe limit to what can be expected from most public sector logistics systems unless such activities are done.

Of the several activities planned for the next reporting period, perhaps the most interesting and challenging is the development of a mathematical match between condom quantities and target groups. AIDSCAP needs a more useful tool to project the numbers of condoms required for a given population and to estimate the numbers of people protected by a given quantity of condoms. The "CYP," or couple-year-of-protection indicator, used in population work, is biologically derived, in part, from a woman's capacity to reproduce and is not directly applicable in AIDS prevention. AIDSCAP will examine the previous attempts to deal with this problem and will develop recommendations as to their utility. Some additional studies may be undertaken to expand the data available for these estimates.



POLICY

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AIDSCAP's policy strategy has remained relevant since it was designed. A technical working group of external experts in the field of HIV/AIDS prevention and development policy provides guidance to the Policy Unit staff, particularly in assessing current issues and identifying resource tools the unit can develop for sharing with field collaborators.

The AIDSCAP Policy Unit has remained fully staffed since February 1993, with only minor breaks related to the replacement of a program assistant and the modeling officer. In addition, the unit has benefited from the services of interns on two different occasions.

The policy strategy incorporates three broad disciplines: policy analysis, modeling, and health economics. AIDSCAP has provided technical assistance across all policy disciplines to 15 countries.

AIDSCAP does not set HIV/AIDS prevention policies for collaborating governments or organizations. Instead, the project supports the efforts of country collaborators in the identification and development of policy issues and the development and implementation of strategies for achieving policy enhancement goals. AIDSCAP provides examples of policy guidelines developed by international organizations or national bodies, facilitates between countries and organizations the exchange of examples (in the form of case studies, notes, and short study tours) of policies and processes, and encourages South-South collaboration.

AIDSCAP has sought to offer an integrated package of technical expertise. While countries do not always take advantage of the entire package, AIDSCAP does seek to assure that countries that are addressing policy aspects of HIV/AIDS prevention place those efforts within a strategic planning context. At the least, this will help assure that a baseline review of the policies and issues exists and that a coordinating team (formal or informal) provides direction for identifying and developing issues that will enhance the policy framework for prevention.

Policy analysis broadly refers to: assessments of the policy situation in countries or particular sectors; assistance in the formulation of strategies for enhancement of prevention policies; training in use of advocacy within the strategy; and development of resource tools for use by those who make and influence policy. AIDSCAP has encouraged country collaborators to view policy as a process, often lengthy and subject to influence through sound data analysis, carefully developed strategies, advocacy, and interagency collaboration.

AIDSCAP has provided policy analysis technical assistance to Jamaica and Kenya, particularly the National AIDS Control Programs (NACPs) in both countries and to the NGO Consortium (75 collaborating NGOs that deal with AIDS prevention and care) in Kenya. Each of these contributions involved a multisectoral review of existing policies and structures and the identification of key issues and potential initiating agencies for enhancing the policy climate. Reports were prepared that analyzed the status of the HIV/AIDS epidemic in relationship to development of



prevention policies. A series of recommendations were offered, including the identification of collaborating agencies to further the policy process.

Technical assistance in the formulation of a policy strategy was provided to Tanzania at an early stage of the USAID-supported AIDSCAP program there. Examples of approaches being pursued in Kenya, South Africa, and Honduras in raising awareness of policy makers and incorporating a multisectoral policy strategy were provided. AIDSCAP has given further assistance in Tanzania by providing resource materials on sensitizing business managers to the need for HIV/AIDS prevention programs and policies for the workplace.

In Brazil AIDSCAP analyzed the potential increase in HIV infections from the country's value added tax and tariffs on the cost of condoms to the end user. The analysis was subsequently used, along with other materials, to encourage reduction or abolition of the taxes. The campaign was partially successful, in that the federal taxes were dropped.

HIV/AIDS prevention in the workplace has been an area of special focus. With two-year support from USAID/Africa/ARTS, AIDSCAP is developing a Private Sector AIDS Policy Presentation (PSAPP). PSAPP materials are designed to sensitize and inform company managers and worker representatives to the potential impact of AIDS on company profits and operations as a means to encourage adoption of prevention programs and policies in the workplace. Development of the materials was preceded by applied research in Kenya and Senegal designed to illuminate current private sector responses to HIV/AIDS. Increasingly, the private sector is seen as an important element in HIV/AIDS prevention. AIDSCAP monitors the responses of the private sector in countries in which it works and provides information about lessons learned and intervention program costs to collaborators in other countries.

AIDSCAP organized and implemented a one-week training workshop in AIDS impact modeling through the Asia Regional Office. Epidemiologists and policy analysts/planners from India, Nepal, Cambodia, Laos, Thailand, the Philippines, and Indonesia received training in the use of projection modeling software (Epimodel) and the application of the outcomes of modeling to policy awareness and analysis. A similar training course is planned for late 1994 in Central America.

Modeling involves the application of mathematical formulas, within software packages, to available demographic and epidemiological data. This allows projections of the future course of the HIV/AIDS epidemic and its impact on population groups to be made. AIDSCAP applies modeling to the policy enhancement process by using the projections to sensitize and inform policy makers and policy influencers about the potential impact of the epidemic if prevention interventions are not implemented.

Technical assistance in modeling, in conjunction with economic analysis, was provided in Côte d'Ivoire, the Dominican Republic, and Honduras. Following internal analysis of the data, Honduran counterparts organized a presentation of



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the results of the modeling for senior level policy makers in government and the private sector. The purpose was to increase the awareness of policy makers to the HIV/AIDS epidemic in Honduras and to stimulate policy and program responses to slow the spread of the HIV virus. Subsequently, the government established a high-level commission to coordinate the national AIDS response. The projections generated through the technical assistance were disseminated to the media and a video is in production to dramatize the projections for a national audience.

The Latin American/Caribbean Regional Office of AIDSCAP has requested that the Policy Unit provide technical assistance to epidemiologists and policy analysts from El Salvador, Guatemala, and Nicaragua. The goal is to develop the skills of these collaborators so they can prepare projections of the socioeconomic impact of AIDS on their countries and effectively present those projections, along with specific recommendations for policy actions, to policy makers and policy influencers in the respective countries.

Documentation for the use of the iwgAIDS simulation modeling package was prepared, as was a User's Guide for Epimodel. The unit is in the process of developing a presentation package that will draw examples from the AIDS Impact Model (AIM) and offer an interactive and policy-directed format. Initial work, using the simulation program SIMULAIDS, began with projections of the impact of behavior change on the future course of HIV/AIDS. The results suggest that enhancing effectiveness of behavior change interventions is more important in lowering HIV seroprevalence than increasing the coverage of the interventions.

AIDSCAP's health economics expertise has been used to develop projections of the socioeconomic impact of HIV/AIDS on health systems and other productive sectors of the national economy. Building on the demographic and epidemiological projections generated by modeling HIV/AIDS, health and cost data are analyzed to illustrate the potential impact of the epidemic. The most extensive work has been done in Honduras and Kenya, with smaller contributions in this area in Côte d'Ivoire. As indicated above, AIDSCAP's technical assistance in Honduras stimulated high level policy responses, which in turn influenced the USAID Mission to significantly increase its support to HIV/AIDS prevention.

A study of the socioeconomic impact of HIV/AIDS on the Kenyan economy was prepared. That report was updated with new data under AIDSCAP. In addition, AIDSCAP has begun to consolidate existing and ongoing research related to socioeconomic impact in Kenya in collaboration with the NACP and staff in several government ministries and the private sector. AIDSCAP work on socioeconomic impact assessments has added a new dimension to the discipline: gender-specific impacts. Initial conceptual work was done by AIDSCAP staff and collaboration with colleagues at the University of Nairobi is providing practical dimensions to the work.

AIDSCAP and USAID/W have collaborated to sponsor the AIDS and Economics Network, an informal grouping of UN, multilateral, bilateral, and NGO agencies



involved in economic aspects of HIV/AIDS. Four meetings of the network have been organized and hosted by AIDS CAP. The meetings provide an opportunity for member agencies to update others on their activities and to discuss issues particular to the discipline.

**ISSUES AND
IMPLICATIONS
FOR THE FUTURE**

Although the HIV/AIDS epidemic and policy responses differ from country to country, the Policy Unit has identified a number of emerging issues that will require effective policy support from AIDS CAP. The following describes some of the policy-related HIV/AIDS issues that AIDS CAP is addressing.

The rising rate of HIV infection among women represents one of the most outstanding and critical challenges in HIV/AIDS prevention. Although women and AIDS issues are receiving greater attention, HIV policies and programs do not consistently reflect women's specific (biological, epidemiologic and social) vulnerabilities to infection — an outgrowth of women's lack of opportunities to inform prevention policies and program design.

Religious responses exist across a wide spectrum, from judgmental attitudes toward people with AIDS, and criticism of condom promotion, to active involvement in care and treatment, to advocacy for prevention. Further, issues of sexuality, especially among young people, cause much unease among religious leaders. It is worth noting that in countries in which the epidemic is more advanced, some religious leaders are struggling to define policies that will encompass the reality of a growing number of deaths.

AIDS deaths are rapidly rising in many countries, making the epidemic a conspicuous reality where it was once considered in abstract or removed terms. The result is that a variety of new issues require tangible legal responses and/or raise a host of ethical considerations. Examples include the acceptability of HIV testing in a variety of settings, assuring confidentiality of test results, and the appropriateness of STD partner tracing.

While a number of projects are addressing HIV/AIDS prevention education in the workplace, far less activity has occurred around workplace policies that will provide protection for workers and maintain productivity and profitability.

Sensitizing policy makers to the looming impact of AIDS has been a primary strategy in many countries. In the Dominican Republic, projections were developed to suggest the demographic and economic impact of HIV/AIDS in the next several years. Widespread media attention to the projections followed and the President signed into law antidiscrimination legislation that had been awaiting action for many months.



To date, many prevention interventions have been funded by international donors. Where will funding come from to maintain and expand interventions that are effective, to purchase condoms and STD drugs, and to replace staff and initiate new programs? Governments in countries in which the AIDS epidemic is well advanced are putting more resources into dealing with the epidemic. Thailand, for example, with 750,000 HIV infected people, budgeted about \$60 million in 1994 to HIV/AIDS prevention. But most countries do not have the resources to invest heavily in either HIV/AIDS prevention or treatment.

As HIV/AIDS has been recognized as more than a health sector problem, countries have sought to develop integrated intervention plans and to establish structures for multisectoral responses. This has not always been easy or straightforward. Government ministries have resisted perceived encroachment upon their jurisdictions and have not been sufficiently motivated to invest resources in HIV/AIDS prevention.

The ability of governments and the private sector to absorb accumulating costs is limited. As HIV-related illnesses and AIDS deaths rise, there will be ever-increasing pressure on health and medical services, on supporting orphans, and legal claims against companies are likely to increase along with the cost of maintaining employees. Policy options that health services can consider include strengthening home/community-based care, creation of hospice facilities, taxes on brotchel consumers, and increasing funds directed to prevention and care. For both health services and business, the most viable and least expensive option to reduce the cost of HIV/AIDS is the creation of aggressive prevention programs.

The private sector is beginning to contribute its resources to HIV/AIDS prevention, but in many cases smaller companies have not acted, or rely upon government resources to train staff and provide commodities. Communities have led the response to HIV/AIDS, organizing counseling, care, educational, and policy responses. Many of these initiatives have occurred with minimal resources. Thus, there are many lessons to be learned in the effective use of resources by building upon these experiences, including further support to community-based initiatives.

Mitigation includes assuring that medical care is provided, families receive training and support in care, and alternative sources of income are identified and made available to families who lose a wage earner. Among the options that AIDS CAP has suggested are: focusing on specific needs of women and women's groups in communities; supporting micro-enterprise credits and related savings programs; and strengthening accepted community-based structures to spread the burden of care and recovery. Despite increasing discussion of home-based and outpatient care, the reality is that such care is expensive for health systems to deliver, can only serve a limited number of people, and is not being supported by development of effective infrastructure and management systems.



The movement of people—men in particular—over long distances in search of and for work has provided the means for HIV to rapidly spread across countries and regions. As HIV becomes more firmly established in rural areas, the implications for rural households and economies will be tremendous. Among the options that countries and companies can consider to reduce HIV transmission related to men working in sites away from their families are: staggered pay periods, closing of bars on pay days, mandated condom distribution at all work sites and expanding availability to consumer outlets in rural areas, and linking HIV prevention interventions with new development projects (i.e. construction) that attract migrant workers.

As countries and collaborating agencies address these and other issues in the future, AIDS CAP will be able to assist in the development of effective strategies. For example, the experiences with the prepackaged STD treatment kit in Cameroon suggest several policy-related considerations that need to be addressed as similar programs are begun in other countries. Cost-effectiveness analysis of prevention interventions, undertaken in collaboration with the Evaluation Unit of AIDS CAP and WHO/GPA, will provide policy makers with some solid options for identifying and funding effective interventions and assuring that these interventions are sustainable.

Workplace issues will remain in the forefront of AIDS CAP policy analysis and monitoring, with a growing emphasis on how workers are collaborating with management or advocating for prevention programs and supportive policies. Gender analysis also will remain a major issue for the unit, with special emphasis on identifying mitigation interventions, such as micro-enterprise development for women in order to reduce vulnerability due to survival sex. AIDS CAP also maintains an extensive network of collaborators in international organizations and within countries. These networks permit Policy Unit staff to remain current on issues, policy strategies and on new data and information that becomes available.

The policy unit will seek to serve AIDS CAP country programs through effective TA and the development of resources local policy influencers can use as tools in their own strategies. For example, a series of short publications setting out the policy rationale for prevention interventions and another series of "How To" guides to policy-oriented data collection, analysis, and advocacy will be prepared, and reports on several topics (such as on religious attitudes and responses to AIDS) will be written and disseminated.



SEXUALLY TRANSMITTED DISEASE (STD)

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The work of the STD Unit is managed by two staff member at headquarters and two regional staff members, with the majority of the technical assistance provided by the three subcontractors or STDs: the Institute for Tropical Medicine (ITM) in Antwerp, the University of North Carolina (UNC) at Chapel Hill, and the University of Washington (UW).

AIDSCAP has specific STD intervention projects in 21 priority and associate countries. These activities include: baseline assessments to determine prevalence and antibiotic susceptibility of STD pathogens; advocacy for syndrome management guidelines with in-country nationals; development of training curricula for clinician and pharmacist training; appropriate laboratory upgrading for the centers of excellence and for clinics; regional training of key STD experts in-country; and baseline ethnographic assessment of STD health-seeking behaviors.

AIDSCAP has field tested simple diagnostics that are being developed for resource-poor settings in conjunction with PATH and USAID. Also, the unit has completed an ethnographic research instrument for targeted intervention research (TIR), a collaborative project between the Behavioral Research, STD and BCC units to assess STD perceptions by clients and providers in selected communities. Field testing of the instrument has begun. In addition, the STD Unit participated in the design of the STD component of the BRU's counseling and testing protocol.

In the area of STDs and reproductive health, AIDSCAP is a technical resource to the USAID Office of Population's Family Planning Services Division on STD/HIV prevention integration with family planning (FP). In December 1993 AIDSCAP hosted a meeting of members of this group to outline research priorities in STD/FP integration. AIDSCAP is also working with the Centre for Development and Population Activities in it study of STD service integration at a family planning clinic in Kenya.

AIDSCAP STD staff and subcontractors have actively participated in regional and worldwide meetings on HIV and STDs with oral and poster presentations at the IXth International Conference on AIDS in Berlin, Germany; the IUVDT Conference in Chiang Mai, Thailand; an international STD meeting in Helsinki, Finland; the VIIIth International Conference on AIDS and STDs in Africa; the Xth International Conference on AIDS in Yokohama; a consultative meeting on priority research issues for the prevention and control of STDs in Africa; a WHO STD treatment guideline meeting in Geneva Switzerland; the International Conference on Population and Development in Cairo; and the VIIth Congress of the Federation of the Asia-Oceania Perinatal Societies in Bangkok, Thailand.

The STD unit has also organized and facilitated regional training and advocacy workshops for STD physicians. These include:

- STD Advocacy Workshop in conjunction with WHO at the International Union of Venereology and Treponematoses (IUVDT) Conference in Chiang Mai, Thailand



- First Latin American STD Managers course in conjunction with the European Community, Latin American Union Against Sexually Transmitted Disease, the Dominican Republic Union Against Sexually Transmitted Diseases, PAHO, WHO, and the International AIDS Society in Santo Domingo, Dominican Republic
- First and Second Francophone STD Managers' Courses in conjunction with the National AIDS Control Program of Senegal, the African Institute of Medicine and Epidemiology in Paris, the Institute of Tropical Medicine (Antwerp), and the AIDS Task Force of the European Community in Dakar, Senegal
- Second International Course on the Control of STDs in Developing Countries in conjunction with the London School of Tropical Hygiene, the Institute of Tropical Medicine (Antwerp), the European Community, and WHO
- First STD Laboratory Course in conjunction with the National AIDS Control Program of Senegal, the African Institute of Medicine and Epidemiology, and the AIDS Task Force of the European Community in Dakar, Senegal.

The AIDSCAP STD staff has worked closely with other organizations and has been active in mobilizing advocacy for a more public health approach to STD control through participation on local and national levels in professional meetings such as:

- The Medical Association of Jamaica STD Management Seminars
- Argentinean HIV and STD Conference
- Philippine Society of Venereologists' Postgraduate Course on STDs
- The Mongolian dermatovenerologist meeting
- The Fifth National Congress of Perinatal and International Symposium on Prevention and Therapy of Perinatal Infection for Mother and Child Health in Indonesia
- The IPPF Family Planning Congress, New Delhi, India.

AIDSCAP also has participated in several technical advisory groups. These included USAID's MotherCare and HHRAA projects and WHO's congenital syphilis materials development group. The STD Unit held an STD technical working group meeting at which the group set priorities for AIDSCAP's STD research activities.



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ISSUES AND IMPLICATIONS FOR THE FUTURE

The AIDS epidemic has generated a growing global recognition of the importance of other sexually transmitted diseases (STDs). In countries around the world, care for clients with STDs is provided in many different settings by a variety of providers with diverse backgrounds and training. This makes it of paramount importance that countries have national STD treatment guidelines that reflect the current etiologic and antibiotic resistance patterns of STDs in the region and appropriate health care provider training and logistical resources to support the implementation of these guidelines. The AIDSCAP STD strategy seeks to provide optimal care for the patient at the point of first encounter with the health care system. The project also emphasizes the management of syndromes of genital ulcer disease and discharges and specific STDs most strongly associated with HIV transmission for which diagnosis and treatment are most feasible. AIDSCAP's approach to ensuring optimal care at the point of first encounter is through the implementation of the WHO/GPA syndrome management guidelines. The syndrome management approach requires the clinician to recognize the constellation of clinical signs from physical examination of the patient and the symptoms that a patient reports and to treat all of the most common pathogens that cause that syndrome in the target geographic area.

Syndromic management of STDs is efficient, practical, cost-effective, facilitates training and supervision of health care providers, delays the development of antimicrobial resistance in STD agents, and includes primary prevention approaches along with treatment. However, there are disadvantages to this approach. The major drawbacks or disadvantages to using the syndromic approach are that some antibiotics may be overused and some patients overtreated, the approach is not suitable as a screening and case finding tool for asymptomatic persons, and there is often physician resistance to use of the approach.

The local acceptability of syndrome management of STDs is often low. Because physicians are trained with a classic clinical and etiologic approach for the diagnosis of STDs, they often persist in ordering laboratory tests despite the disadvantages of many of these tests. These disadvantages are part of the argument for using the syndromic approach.

Overcoming physician resistance is not the only prerequisite to the introduction of a syndrome management approach to STD care. Implementation of such an approach first requires the establishment of management flow charts, or algorithms, to guide provider management of patients, that are developed based on taking into account the local prevalence rates of STDs as well as antibiotic resistance data and drug availability. Algorithm development requires data that is not always available or easy to locate in many countries. To address this last issue, most of AIDSCAP's STD projects have required the generation of local STD data as part of algorithm development or as part of the final approval process by the technical advisory groups responsible for STD prevention and control policies. Once local data is generated it is critical to collaborate with local medical providers and administrators to come to consensus on the algorithms that will become a part



of the national guidelines for STD prevention and control. As part of this assessment, behavioral data is often collected to assist in the design of communication strategies to be used in algorithm development for women. In addition, STD prevalence data and gonococcal isolates are obtained to conduct antimicrobial sensitivity testing. This data is often necessary in order to advocate for the more effective but more expensive antimicrobials to be included on the essential drug list of the country.

In addition to providing data for decision making, these baseline evaluations also contribute greatly to capacity building by improving laboratory diagnostic capabilities in reference laboratories, exposing STD counterparts to research methodologies, and improving the data management skills of collaborating institutions.

AIDSCAP's approach to the introduction of the syndrome management varies by country but has included the following:

- Mobilizing advocacy through sponsorship in international courses and workshops as well as presentations to national medical committees
- Technical assistance and support to in-country technical advisory committees during the design of the country management guidelines
- Linkages with other donor institutions in countries to ensure broad implementation of recommendations and adequate resources for recommendations
- Technical assistance and support to in-country institutions in protocol development, implementation, and analysis of baseline evaluations and algorithm validations
- Technical assistance in the development of training materials and training plans for in-service and pre-service training.

In Jamaica an evaluation was completed that determined the diagnostic validity (sensitivity, specificity, and predictive values) of two flow charts for the diagnosis and treatment of abnormal vaginal discharge in women. Laboratory tests were used to determine the actual infection status of the women. Over half of the women had a documented STD. The prevalence of STDs were as follows: chlamydial infections - 25 percent; gonococcal infection - 17 percent; gonococcal and/or chlamydial cervical infection - 34 percent; and trichomoniasis - 26 percent. Vaginal yeast infections, which are not sexually transmitted, were found in 35 percent of the women. Thirteen percent of the women had reactive syphilis serology.

The algorithm that relied on clinical examination alone had a sensitivity of 73 percent and a specificity of 55 percent, while the WHO/GPA algorithm that incorporated a risk assessment had a sensitivity of 85 percent and a specificity of 40 percent. These results were discussed with STD policy makers and the entire



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health care team of the central clinic where the evaluation was performed. Protocols based on these results will be implemented island-wide in all the public health clinics. Additionally, the results will be reported at the next seminar of the Medical Society of Jamaica.

Based on the study results, additional changes were made in the running of the Jamaican central STD clinic. Routine gonococcal cultures on all women were discontinued. Personnel resources in the laboratory are being directed now towards implementation of antenatal syphilis screening in a large urban antenatal clinic. Monetary resources saved by discontinuation of routine gonococcal cultures will be used to do intermittent cross-sectional assessments to monitor the prevalence trends. Finally, the institution of syndrome management in the clinic has reduced waiting times in the clinic by more than half, thereby improving patient care because fewer patients are turned away.

These consensus-building activities are essential for sustainability of the public health approach to STD control programs. They do, however, require resources and time. The persistent constraint in many countries in both these consensus-building activities and in actual project implementation is the scarcity of effective antimicrobial therapy.

The major thrust of AIDSCAP's STD efforts over the next two years will focus on the following: expanding the number of countries in which health providers implement a syndromic approach to STD treatment and comprehensive STD case management; developing training guidelines and client and provider materials based on ethnographic and epidemiologic studies; exploring new initiatives such as mass therapy; and collaborating with AIDSCAP subcontractors and other donors in exploring effective approaches to making appropriate drugs affordable and accessible. In addition, there will be a continued and expanded effort to disseminate findings of studies and tested strategies for improved STD prevention to professional groups at the local and international levels through publications, presentations, and training.

A major barrier to implementing the syndromic approach in many countries has been the lack of local STD data to use in convincing STD program leaders and providers of the validity of the recommended algorithms. In order to do this, it is critical that studies be initiated or completed as an effective way to convince local leaders and providers of the effectiveness and validity of the algorithms.

Improved case management will be facilitated by working with the BCC Unit to develop joint STD plans that include materials development based on the results of targeted intervention research studies and other STD country-specific information.

Finally, AIDSCAP will seek to take a critical look at the ways in which countries' policies related to STD programs often pose real and substantial barriers to improving outcomes. Policies such as charging poor women fees for syphilis testing, informing brothel owners of the HIV results of commercial sex workers, and



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denying services to adolescents are all counterproductive to the results sought through other endeavors such as epidemiological studies and provider training. It is only through concentrated work in the form of symposia, reports, and joint critical policy analyses with the appropriate local leaders, providers, and policymakers that other efforts in training, materials development, and treatment algorithms will reap the intended outcome of improved STD prevention and control.



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EVALUATION

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AIDSCAP's evaluation efforts have grown and matured along with the project itself, as AIDSCAP moves from an emphasis on design and planning into full-scale implementation, finalizing baseline assessments, initiating midterm internal reviews, and revising the process evaluation system. During FY94, evaluation staff at headquarters and regional levels continued to be heavily involved in the design phases of country programs, as well as designing evaluation plans for the more than 150 subprojects currently funded under the project.

The Evaluation Unit at headquarters consists of two epidemiologists, a medical anthropologist, two associate evaluation officers, a database and information coordinator, and two staff assistants. Each regional office has an evaluation officer, as does one country office (Brazil). The current Asia regional officer as well as the Brazil officer were hired during FY94. The Asia officer has a program assistant, the Africa officer has two assistants, and the LAC officer has one. Other country programs, for instance, Haiti and Jamaica, contract evaluation activities through implementing agencies with skills in both qualitative and quantitative evaluation methodologies.

AIDSCAP evaluation staff revised and redistributed model subproject and country program logframes (subproject design summaries) and model evaluation sections for subagreements to guide subproject design teams in drafting evaluation plans.

During FY94 AIDSCAP produced and distributed two evaluation tools modules in FY 94, designed to inform and guide project staff and collaborating organizations on specific elements of AIDSCAP evaluation approaches. These are Module 2: Conducting Effective Focus Group Discussions and Module 3: Incorporating Evaluation into Project Design. Four other modules on surveying and sampling, qualitative methods for evaluation, conducting process evaluation, and evaluating STD services are in progress. The first module, Introduction to AIDSCAP Evaluation, was translated into Spanish in the Dominican Republic and into Portuguese in Brazil for wider distribution among implementing agencies.

AIDSCAP evaluation staff also conducted and participated in a number of workshops and seminars during the past year focusing on evaluation issues. These included:

- An evaluation methods seminar in Ethiopia
- An evaluation technical strategy presentation at an implementing agency workshop in Brazil
- Lectures at CDC in Atlanta on syndrome-based sentinel surveillance of STDs and on evaluating HIV prevention programs as part of the CDC's International Epidemiology Training Course
- A presentation on Measuring the Unmeasurable in a panel at a Center for Development Information and Evaluation (CDIE) summer seminar at USAID



- The Johns Hopkins' Child Survival HIV Prevention Task Force Workshop to develop a set of indicators for measuring progress in incorporating HIV prevention activities into child survival projects
- The Reproductive Health Indicators Working Group efforts to develop indicators for the planned inclusion of various reproductive health issues, including STD and HIV prevention, into family planning services and programs.

After a number of months of testing a generic set of process indicator forms (PIFs), AIDSCAP's system was redesigned to make it easier for implementing agencies to report on their monthly activities. Using the set of output level indicators and activities as summarized in each subagreement logframe, the new PIFs exactly reflect the targeted outputs of each subproject. Thus, as each implementing agency fills out its monthly PIF, the program manager reviews the agreed-upon set of deliverables for the project.

At the regional office, these indicators, unique to each project, are translated into generic categories. These include number of people trained, number of people educated, number of condoms sold or distributed free, and number of media events held. These generic categories are then aggregated and reported for the entire project. Redesigning this system has dramatically improved the efficiency of this component of the project's MIS system. Improvements in the PIF system make it much easier to provide feedback to the field, compile statistics for the quarterly country program and annual reports, and respond quickly to requests for data from a multitude of sources.

In September 1994 all AIDSCAP evaluation staff convened in Arlington, Virginia, to review the AIDSCAP evaluation strategy and country progress. The group recommended a set of relatively minor changes, but found that the core elements of the strategy remained sound and relevant. Participants also reviewed the status of evaluation efforts in each priority country and determined technical assistance needs to get or keep programs on track. The multiple evaluation methodologies employed in the project for measurement of outcome and process indicators were reviewed, and the group met with representatives of all other project units to revisit specific issues relevant to the other strategic foci of AIDSCAP.

AIDSCAP maintains the Worldwide HIV/AIDS Database for USAID, which serves various reporting needs on worldwide HIV/AIDS prevention. Financial and programmatic data are collected once a year from all USAID-funded contractors conducting HIV/AIDS prevention activities. During FY94, data collection and processing for FY93 were completed. Staff responded to requests for a variety of reports from the database, including the USAID FY93 Report to Congress. Each year a descriptive report is published from the database for distribution among USAID program managers, USAID contractors, and AIDSCAP staff.



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ISSUES AND IMPLICATIONS FOR THE FUTURE

A number of issues have been critical to AIDSCAP's progress to date in the area of evaluation and will likely remain critical for the life of the project and beyond. These include: the ambitious goals and objectives set for AIDS prevention in general and this program in particular; the difficulties in measurement due to the nature of sexual behavior and the complexity of the programs designed to influence it; and translating the data collected into intelligible descriptions of situations, inputs, and effects.

The goal of most AIDS prevention programs—stopping the spread of HIV in the host country—is unattainable in a five-year project life span. However, that does not mean that systems to monitor progress toward that particular goal by measuring biologic indicators of HIV and STD should not be implemented or established. If the systems are not in place now in a functional sense, valid baseline data needed to assess success in the more rational 20 to 25 year time span for attainment of control of HIV will not be available. Most countries have insufficient AIDS, HIV, and STD surveillance and reporting systems to support any detailed and rigorous analysis of the biologic impact of HIV prevention activity. Even when they are present, these measurement systems have weaknesses. Because of the long incubation period between infection and illness, the number of AIDS cases reflects the status of the epidemic five to ten years in the past. This information is greatly influenced by incomplete reporting, inaccurate diagnoses, and uneven access to medical care, in addition to other variables.

Even if all HIV transmission stopped tomorrow, HIV prevalence rates would most likely continue to rise slightly for six to twelve months, remain steady for five to seven years, and only then begin to slowly decrease as the majority of HIV-infected people moved into the symptomatic and ultimately fatal stages of the disease. Therefore, measuring changes in HIV prevalence is not a particularly sensitive method for ascertaining success in changing personal sexual or drug-using behavior.

The difficulties in measurement of behaviors related to HIV prevention are legion, and many, such as the bias dangers related to sampling issues, and self-reporting of sexual behaviors, and have been discussed in multiple fora. These are the easy challenges that can be addressed through the actual measurement process. The real challenges arrive with the attempt to define the relationship, causal or otherwise, between program activities and the measured behaviors. The country context and environment, in all senses of those words, are critical to progress in the area of HIV prevention. Recognizing and then describing those influences is very challenging, which is why there is an emphasis on qualitative information in the AIDSCAP program. Communicating evaluation data as useful information to inform subsequent decision making is a major challenge. The complexity of the problem does not lend itself to either a 10-second sound bite or to two pages per country in a report of this nature. Perspectives need to be broadened beyond the boundaries of a particular program or activity when evaluating it; programs and activities should not be partitioned into discrete components or they lose their value.



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All of the aforementioned issues also relate to another, assessing the cost-effectiveness of HIV prevention efforts. The challenge is that there is no viable, standard unit of effectiveness. Unlike family planning, where women can get pregnant only a finite number of times each year, and that number is essentially the same in all women, risk of HIV at either a country or individual level of analysis is highly variable, and may make any such standardization impossible.

In conclusion, evaluation continues to play a critical role within the wider AIDSCAP strategic approach. The focus in the remaining two years of the project will be on synthesizing and analyzing the information that is being collected throughout the priority country programs and their subprojects, as well as associate country activities. Dissemination of the findings as they become available, will be a high priority for all AIDSCAP evaluation staff.



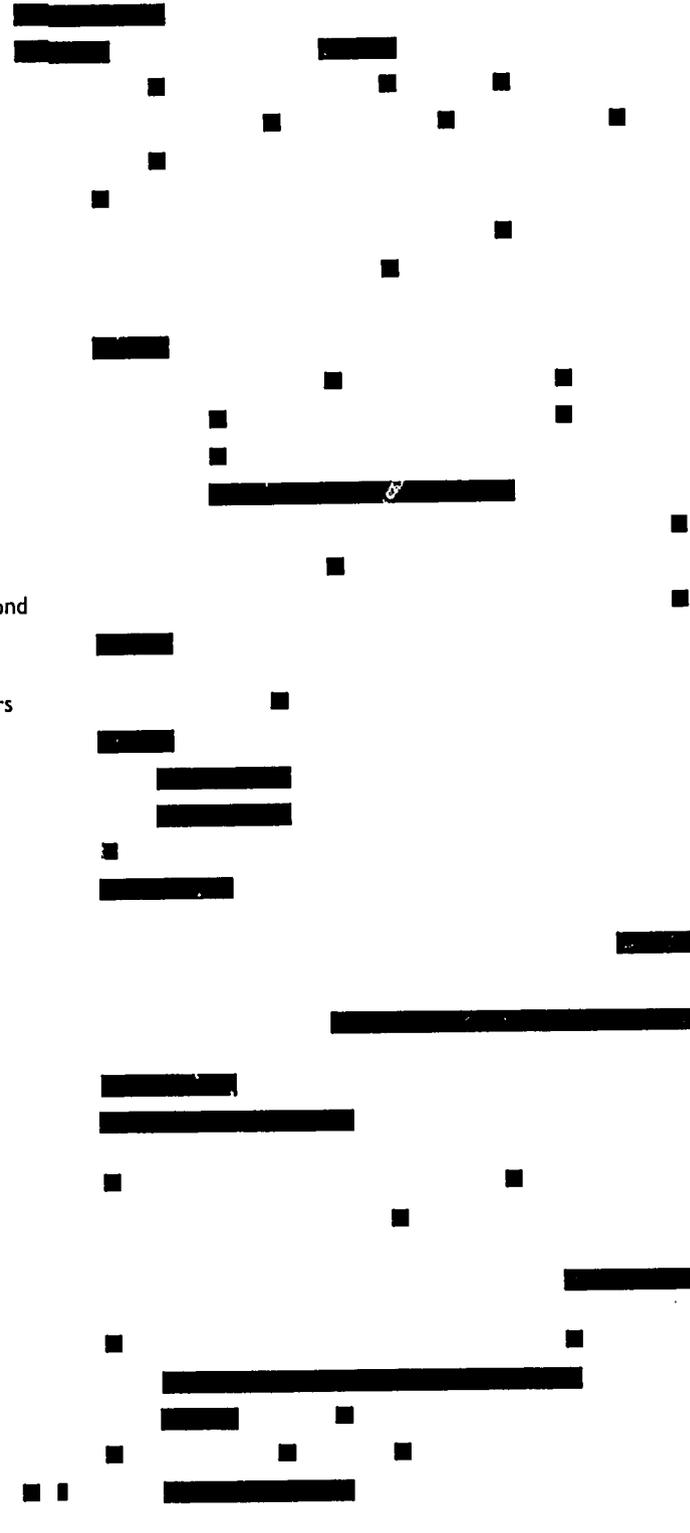
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AIDSCAP Annual Work Plan

O N D J F M A M J J A S

Activities

- Revise Program Management Manual
- Disseminate Evaluation Tools
- Publish AIDSCAPTIONS
- Publish quarterly reports
- Publish annual report
- TAG Meeting
- Prevention Conference
- Publish STD Handbook
- Complete Capacity Building Inventory
- Assessment of capacity building skills
- Capacity building workshops
- Regional gender workshops
- Inaugurate AIDSCAP Women's Councils
- Initiate female condom research
- AIDS/Women's Experience Book
- Booklet: Cairo: Women and AIDS
- 4th World Conference on Women and Beyond
- Initiate cost-effectiveness review of AIDS prevention
- Initiate study on attitudes of religious leaders
- Create IEC materials database
- Revision of BCC strategy
- BCC TWG meeting
- Automate condom sales report
- Prepare global projections for condom demand and supply shortfall
- Consultation on condoms needed to avert HIV infection
- Develop OR protocols for social marketing of female condom
- Complete C&T study protocol
- Complete concept papers for behavioral research
- BRU TWG meeting
- WHO consensus meeting on STD algorithm validation
- Finalize STD empiric prophylactic protocol and identify sites
- Facilitate STD managers' course
- Complete field tests of TIR
- UNICEF Information Support
- UNICEF Mass Comm TSG Activity
- UNICEF Sex and Reproductive Health TSG Activity

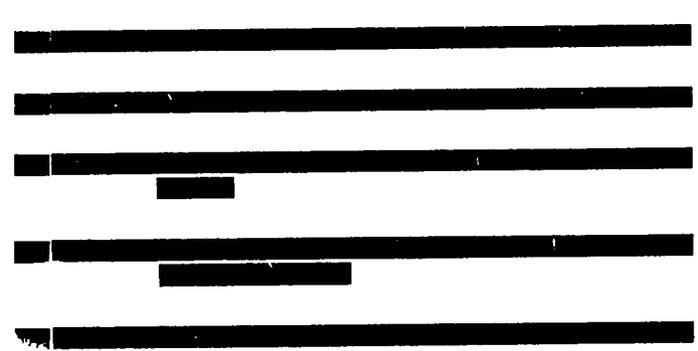


Condensed Country Workplans

Number in parentheses indicates subprojects involved

AFRICA

- Cameroon
- Ongoing implementation (8)
- Côte d'Ivoire
- Ongoing implementation (1)
- Ethiopia
- Ongoing implementation (1)
- New activity launched (1)
- Kenya
- Ongoing Implementation (7)
- New activities launched (7)
- Lesotho
- Ongoing implementation (3)



Mali
 Ongoing implementation (1)
 Project close-out

Morocco
 Ongoing implementation (1)
 New activity launched (1)

Niger
 Ongoing implementation (1)

Nigeria
 Ongoing implementation (9)
 New activity launched (1)
 Program review

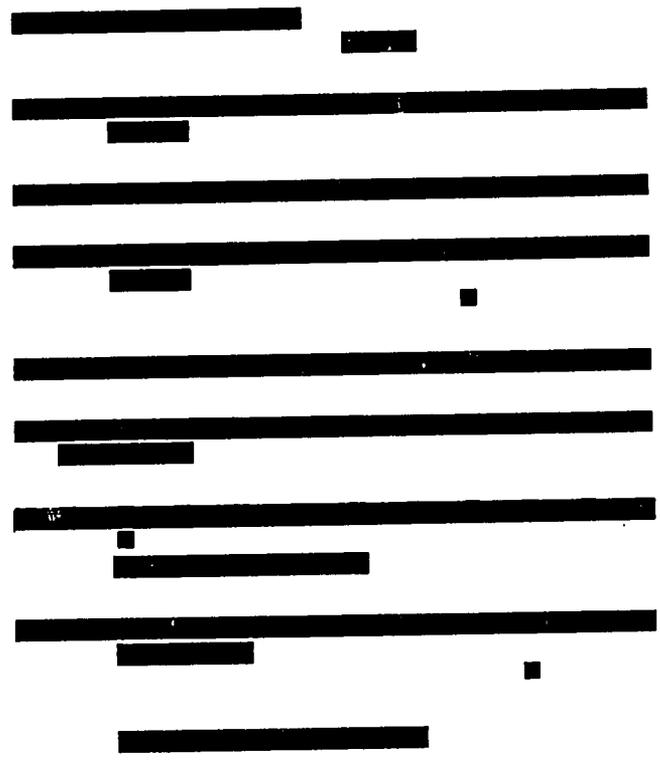
Rwanda (refugees)
 Ongoing implementation (3)

Senegal
 Ongoing implementation (8)
 New activities launched (3)

South Africa
 Ongoing implementation (2)
 New activity launched (1)
 Design and initiate (5)

Tanzania
 Ongoing implementation (7)
 New activity launched (3)
 Program review

Zimbabwe
 Design and initiate (5+)



ASIA

Asia Region
 Ongoing implementation (1)

Bangladesh
 Ongoing implementation (1)

India
 Ongoing implementation (1)
 Design and initiate (5+)

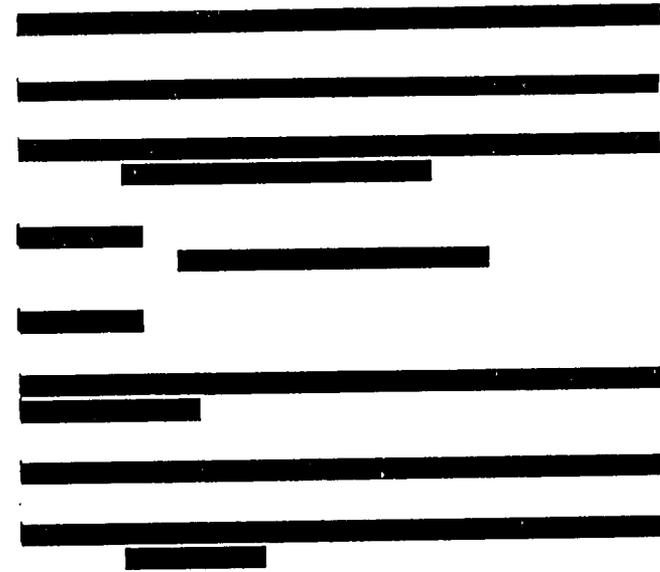
Indonesia
 Ongoing implementation (1)
 Design and initiate (5+)

Laos
 Ongoing implementation (1)

Nepal
 Ongoing implementation (4)
 New activities launched (2)

Philippines
 Ongoing implementation (2)

Thailand
 Ongoing implementation (13)
 New activities launched (3)



LATIN AMERICA AND CARIBBEAN

Brazil
 Ongoing implementation (9)
 New activities launched (3)

Costa Rica
 Ongoing implementation (1)

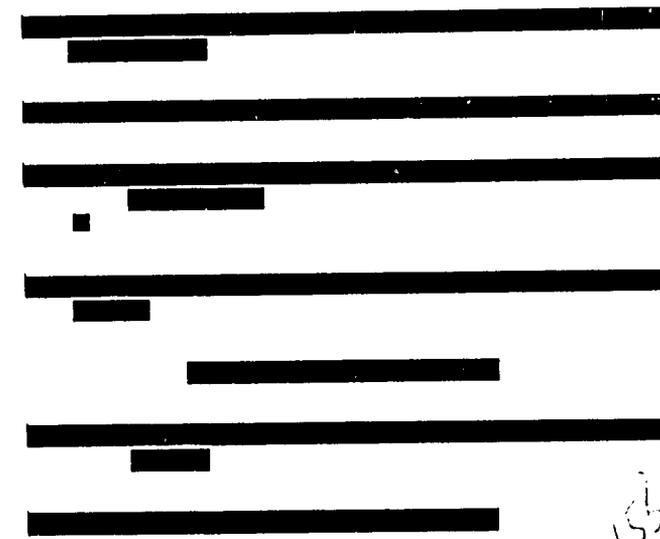
Dominican Republic
 Ongoing implementation (5)
 Design and initiate (3)
 Program review

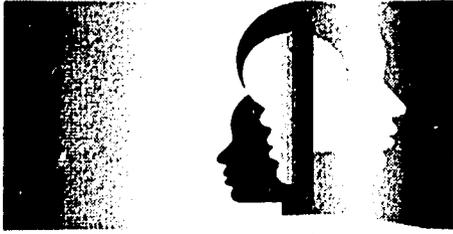
Haiti
 Ongoing implementation (9)
 New activities launched (2)

Honduras
 Design and initiate (6)

Jamaica
 Ongoing implementation (13)
 New activity launched (1)

Mexico
 Ongoing implementation (1)





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FINANCIAL

SUMMARY



ADD-ONS AND OYB TRANSFERS BY REGION

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Family Health International/AIDSCAP
ADD-ONS AND OYB TRANSFERS BY REGION
COOPERATIVE AGREEMENT DPE-5972-A-1031
CONTRACT HRN-5972-Q-00-4002

SEPTEMBER 30 1994		Fiscal Year 1994	Prior Fiscal Years	Total
AFRICA	Africa Regional	218,500	308,675	527,175
	Burundi		490,894	490,894
	Cameroon		1,550,000	1,550,000
	Côte d'Ivoire		79,776	79,776
	Ethiopia		2,465,000	2,465,000
	Kenya	1,400,000	1,800,000	3,200,000
	Lesotho		624,000	624,000
	Malawi		400,000	400,000
	Mali		475,000	475,000
	Morocco	775,000		775,000
	Niger	110,000	40,000	150,000
	Nigeria		4,720,000	4,720,000
	Rwanda		4,200,000	4,200,000
	Senegal	3,900,000		3,900,000
	South Africa	2,323,000	2,000,000	4,323,000
	Tanzania	3,000,000	3,196,200	6,196,200
	Uganda		200,000	200,000
	Zimbabwe	3,438,312		3,438,312
	Subtotal	15,164,812	22,549,545	37,714,357



ASIA	Asia Regional		2,500,000	2,500,000
	India		320,500	320,500
	Indonesia		300,000	300,000
	Nepal	500,000		
	Subtotal	500,000	3,120,500	3,620,500
LATIN AMERICA/ CARIBBEAN	LA/C Regional		638,000	638,000
	Bolivia	49,804		49,804
	Brazil	1,000,000	2,401,000	3,401,000
	Colombia		75,000	75,000
	Costa Rica		150,000	150,000
	Dominican Republic	2,400,000	850,000	3,250,000
	Ecuador		298,000	298,000
	Haiti	792,820	4,000,000	4,792,820
	Jamaica	1,117,414	1,965,000	3,082,414
	Nicaragua	130,000		130,000
	Subtotal	5,490,038	10,377,000	15,867,038
OTHER	CDC		100,000	100,000
	NIAID		400,000	400,000
	Women in Development	390,000	192,000	582,000
	Subtotal	390,000	692,000	1,082,000
	TOTAL	21,544,850	36,739,045	58,283,895

The above information does not include FHI's matching contribution of \$751,627.



AIDSCAP FY94 EXPENDITURES

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OCTOBER 1, 1993 - SEPTEMBER 30, 1994
PRELIMINARY, UNAUDITED FIGURES

Country Programs		23,742,823
Headquarters Support to Country Programs		7,838,518
Program Management	1,600,634	
Sexually Transmitted Diseases	1,478,567	
Condoms	1,138,619	
Behavior Change	1,073,375	
Behavioral Research	816,882	
Policy	394,831	
Information Dissemination	739,009	
PVO Program	251,060	
Evaluation	345,541	
AIDSCAP Administration		2,329,435
TOTAL AIDSCAP PROJECT		33,910,776



AIDSCAP EXPENDITURES

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OCTOBER 1, 1993 - SEPTEMBER 30, 1994
PRELIMINARY, UNAUDITED FIGURES

ASIA	Bangladesh	3,220
	India	154,440
	Indonesia	204,818
	Nepal	355,319
	Philippines	93,116
	Sri Lanka	16,452
	Thailand	1,677,770
	Asia Region	1,387,258
	Headquarters support to country programs	1,285,045
	Subtotal	5,177,438
LATIN AMERICA/ CARIBBEAN	Bolivia	38,426
	Brazil	1,497,994
	Colombia	21,549
	Costa Rica	76,961
	Dominican Republic	948,539
	Ecuador	41,189
	Haiti	2,279,962
	Honduras	107,296
	Jamaica	2,020,666
	Mexico	58,354
	Latin American Region	688,974
Headquarters support to country programs	2,568,480	
	Subtotal	10,348,390



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AFRICA	
Burundi	28,816
Cameroon	879,002
Ethiopia	868,177
Ivory Coast	161,542
Kenya	639,974
Lesotho	186,331
Malawi	130,437
Mali	162,987
Morocco	2,494
Niger	66,655
Nigeria	847,440
Rwanda	943,047
Senegal	1,275,642
South Africa	819,401
Tanzania	1,851,293
Uganda	33,117
Zimbabwe	81,698
Africa Region	3,092,467
Headquarters support to country programs	3,984,993
SubTotal	16,055,513
AIDSCAP Administration	2,329,435
TOTAL AIDSCAP PROJECT	33,910,776

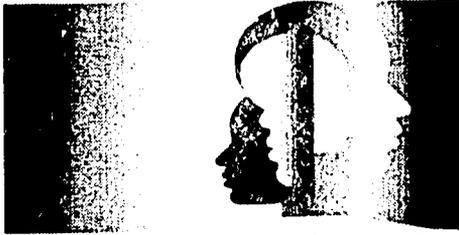


SELECTED PRESENTATIONS AND PUBLICATIONS

165

FY 1994 Publications

- Asamoah-Adu A., Weir S., Pappoe M., Kanlisi N., Neequaye A., and Lamptey P.**
Evaluation of a targeted AIDS prevention intervention to increase condom use among prostitutes in Ghana. *AIDS* 1994, 8:239-246.
- Cohen M., Dallabetta G., Laga M. and Holmes K.**
A New Deal in HIV Prevention: Lessons from the Global Approach. *Annals of Internal Medicine*. Feb 1994: 340-341.
- Costello Daly C., Helling-Giese G.E., Mati J.K., Hunter D.J.**
Contraceptive Methods and the Transmission of HIV: Implications for Family Planning. *Genitourin Med.* 1994; 70:110-117
- Costello Daly C., Maggwa N., Mati J.K., Solomon M., Mbugua S., Tukei P.M. Hunter D.J.**
Risk Factors for Gonorrhoea, Syphilis, and Trichomonas Infections Among Women Attending Family Planning Clinics in Nairobi, Kenya. *Genitourin Med.* 1994; 70:155-161.
- Forsythe S. and Roberts M.**
Measuring the Impact of HIV/AIDS on Africa's Commercial Sector: A Kenyan Case Study. *AIDS Analysis Africa*. 1994; 4(5).
- Génécé, E.**
Le point sur les interventions de controle et lutte contre le SIDA et les MST. *Forum Libre*. 1994; No. 16.
- Hanenberg R.**
Impact of Thailand's HIV-control programme as indicated by the decline of sexually transmitted diseases. *The Lancet* 1994; 344.
- Lamptey P. and Coates T.**
Community-Based AIDS Interventions in Africa. *AIDS in Africa*. Essex M, Mboup S, Kanki P, Kalengayi M (Eds.). Raven Press, Ltd., New York, 1994.
- Mugrditchian D. and Benjarattanaporn P.**
STD trends in Bangkok give room for cautious optimism in the fight against AIDS. *AIDS in Asia*. 1994; 3.
- Numex, C., Flores, M., Forsythe, S., Sweat, M.**
Socio-Economic Impact of HIV/AIDS in Tegucigalpa & San Pedro Sula, Honduras. Arlington, Virginia: AIDSCAP/Family Health International, 1994.



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Roberts M.

Conducting a Workplace HIV/AIDS Policy Needs Assessment: A User's Guide. Arlington, Virginia: AIDSCAP/Family Health International, 1994.

AIDScaptions, Vol.1, Nos.1,2,3, AIDSCAP/Family Health International, Arlington, VA. 1993-1994.

Research monographs published in Asia:

Sexual Networking in 5 Urban Areas in the Nepal Terai (1994)

Behavioral risk assessment for HIV/AIDS among workers in the transport industry, Papua New Guinea (1994)

FY 1994 Oral Presentations

Lamprey, P.

Participant, STDs: Epidemiologic Realities and Rational Public Health Policy Meeting, UNC-CH, 10/8/93.

Ankrah, M.

Moderated panel with AIDSCAP colleagues Wendy Githens, Kari Hartwig and Jessica Price on "Designing AIDS Presentation Projects with an Impact on Women" at the Association for Women in Development's Sixth International Forum, Washington, DC, 10/22/93.

Calderón, R.

"Development of HIV/AIDS Prevention and Control Programs: National, Technical Strategies and Lessons Learned," Oral Presentation at the IXth Biannual Congress on STD's & IIIrd Pan American Conference on AIDS. Cartagena de India, Colombia November 3-7, 1993

Lamprey, P.

Presentation: "AIDS Prevention in Africa," Baylor College of Medicine, Houston, Texas 11/13/93.

Roberts, M.

Discussant, "AIDS in Africa" panel. Annual Conference of the African Studies Association, Boston, Massachusetts, November 1993.



**PRESENTATIONS
AT THE
VIIIITH
INTERNATIONAL
CONFERENCE ON
AIDS AND STDs
IN AFRICA,
MARRAKECH,
MOROCCO,
DEC 6-13,
1993**

Madando

"Implementing Community-Based Prevention and Support for HIV-Positive Mothers and Their Families in South Africa."

Tchupo

"Evaluation of Social Marketing Program for the Treatment of Urethritis in Men in Cameroon."

Field

"Community based, Institution based and General Population based: General Approaches to Prevention Lessons Learned," (Pre Conference Training).

Ankrah

"The Private Sector AIDS Policy Presentation Package," (Pre Conference Training).

Ella

"Self-Financing of AIDS Prevention Activities by CSWs—Is it Possible?" (Roundtable).

Mbuya

"Defining a Risk Score for STD Treatment for Women in 7 Truck Stops in Tanzania," (Roundtable).

Schwarzwalder, T.

Presentation on World AIDS Day at the Smithsonian on the global HIV/AIDS situation, December 1, 1993.

Sweat, M.

Presentation on the current status of the international AIDS epidemic to a meeting of the South-Eastern AIDS Training Network, Charleston, South Carolina, 2/3-6/94.

de Zoysa, I.

Presentation on the design of a prospective study of a multisite Counseling and Testing Efficacy Study, to a meeting of external advisors on the "Context of Counseling Interventions in the Context of Voluntary Testing and Counseling" sponsored by the World Health Organization, Global Programme on AIDS, Geneva, Switzerland, 2/12-13/94.



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Lamprey, P.

Telecast, Worldnet, 3/17/94.

Hughes, P.

"The Principles and Success of Condom Social Marketing," Asian Journalist Workshop in Bangkok Thailand, 3/24/94.

Dubow, J.

"Peer Education and AIDS Prevention: An African Experience," George Washington University, School of Public Health, Washington, DC, March 1994.

Ankrah, M.

Presented a paper, "AIDS: Strengthening the Family" to the All Africa Church Consultation on AIDS, arranged by MAP International (an AIDSCAP PVO Grant recipient) April 24-30, 1994, in Nairobi, Kenya.

Lamprey, P.

Panel on AIDS: "Steps toward Howard University Containing the AIDS Crisis" 4/7/94.

Lamprey, P.

Panel member: "Data and Research Priorities for Arresting AIDS in Sub-Saharan Africa," National Academy of Sciences Committee on Population, Washington, DC, 5/12-13/94.

Hollerbach, P.

Chairperson, "International Health" session at the annual meeting of the Population Association of America, Miami, Florida, May 6, 1994.

Denison, J.

Presentation on "HIV and AIDS," American Red Cross, The Charles County Public Health Department in Waldorf, Maryland, for court appointed teens in a drug outpatient program. Presentations given June 2, July 12, 26, 28 and August 1, 1994.

Hogle, J.

"Setting Objectives and Measuring Results in HIV/AIDS Programs—A Panel Discussion: Victor Barnes, Jan Hogle, Jerry Sullivan of Macro International," given at the CDIE summer seminar in Washington, DC, 8/11/94.



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**ORAL
PRESENTATIONS
GIVEN AT THE
XTH
INTERNATIONAL
CONFERENCE
ON AIDS,
YOKOHAMA,
JAPAN
AUGUST 7-12,
1994**

Ella

"Mobilization of Students for STDs/AIDS Prevention in Universities in Cameroon."

Forsythe

"Measuring the Impact of HIV/AIDS on Africa's Commercial Sector"

Gomez

"Projections of the AIDS Epidemic In the Dominican Republic."

Desormeaux

"Introduction of Partner Referral & Treatment for Control of Sexually Transmitted Diseases in a Poor Haitian Community."

Terto

"AIDS Prevention for Men Who Have Sex With Men in Rio de Janeiro and Sao Paulo."

Ankrah, M.

"AIDS: Culture and the Status of Women." In Cairo, Egypt, September 4, 1994 presented a paper to the Panos Institute International Media Seminar to Journalists on the topic

Ankrah, M.

International Conference on Population and Development at Cairo (September 5-13, 1994) moderated a panel on "Women and AIDS" as a component of the FHI Symposium.

Goodridge, G.

"Developing Rationales for AIDS Care," at "WHO Consultation on Rationales for Care in Resource Constraint Settings," WHO, Geneva, Switzerland, Sept 20-22, 1994.

Ryland, S.

"Surveillance of Sentinel STD Syndromes to Monitor HIV/AIDS Prevention" and "Evaluation of Prevention" lecture in International Course in Surveillance and Applied Epidemiology for HIV and AIDS, Centers for Disease Control, Atlanta GA, 9/26/94.



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Dubow, J.

Regional AIDS Control and Prevention Plan, the World Bank,
Ougadougou, Burkina Faso, 9/94.

Roberts, M.

Presented, "Emergence of Gay Identity and Gay Social Movements in
Developing Countries: The AIDS Crisis as Catalyst" at Annual Meeting of
the American Political Science Association, New York, 9/94.