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AIDS Technical Support Program (ATSP) Technical Review

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Glossary of Definitions

Sexually Transmitted Infections (STI): All infections transmitted through sexual contact, whether with or without symptoms. STIs include: HIV, gonococcal, chlamydia, syphilitic, trichomonas, chancroid, human papilloma virus, and herpes simplex virus infections.

Sexually Transmitted Diseases (STD): STI infections which present clinically manifest symptoms. STDs include: AIDS, gonococcal urethritis and cervicitis, chlamydia urethritis and cervicitis, syphilis, genital warts and cervical cancer, genital herpes.

HIV: An STI known as Human Immunodeficiency Virus, which causes the specific STD AIDS.

Syndromic Treatment of Curable STDs: Refers to a simplified approach to the clinical management of curable STDs, which recommends specific treatments based on the symptoms that the patient presents, e.g., urethritis, genital ulcer disease (GUD), vaginal discharge, etc., as opposed to clinical diagnosis or etiologic diagnosis.

Executive Summary

A. Introduction and Overview

The AIDS Technical Support Project (ATSP) was initially authorized in 1987. The project has had two distinct phases, beginning with a start-up or learning phase (Phase I) from 1987 to 1991. The second phase (Phase II) of the ATSP began in 1992 and will terminate in August 1997.

USAID will soon design the third Phase of this critical project. Given the changing trends in the HIV epidemic and promising advances in the field of HIV/AIDS prevention and control, careful strategic planning for this next phase would maximize USAID's comparative advantages through the most effective implementation and coordination of the most successful and most promising program interventions. This report will assist in this process by:

- summarizing the technical lessons learned from current state-of-the-art HIV/AIDS prevention and control interventions and recommending which existing and/or new approaches should be incorporated into the future project design; and

- summarizing the experience and lessons learned to date in measuring (monitoring and evaluating) HIV/AIDS program performance and recommending future best practices.

A two-person team carried out this evaluation from April through June of 1996. The team gathered its data through interviews with over 40 key informants with a concurrent review of relevant project documents (See Annex A for a list of documents consulted and Annex B for a list of persons contacted).

B. Key Conclusions

1. Understanding the Global STI/HIV Epidemic

The 1994 report "USAID Responds to HIV/AIDS" estimates that 10 million men, 7 million women, and 1.5 million children have been infected with HIV and that by the year 2000 this number will increase by another 20 million. While the HIV epidemic appears to be reaching maturity in regions of sub-Saharan Africa, other parts of the world, such as Asia, are seeing dramatic increases in new HIV infections. In addition, the World Health Organization (WHO) estimates that 333 million new cases of sexually transmitted diseases (STDs) other than HIV occur every year and that the number of TB cases will rise from 7.5 million in 1990 to 10.2 million in the year 2000. Half of this increase is due to HIV/AIDS.

2. Lessons Learned and Unmet Needs

In response, USAID has emerged as the global leader in addressing the HIV epidemic by developing global standards of practice for the prevention of HIV. The ATSP, Phase II has supported STI/HIV prevention and control through three major interventions (STI Reduction, Condom Social Marketing, and Behavior Change Communication) and several supporting interventions (Behavior Research, Policy Reform, Monitoring and Evaluation, Capacity Building, and Women's Status/Empowerment).

In the area of **STD/STI reduction**, experience from the field demonstrates that syndromic management is an effective approach to diagnosis and treatment of symptomatic STIs in resource poor settings; sufficient supplies of STI drugs are critical for effective STI programs; the Targeted Intervention Research (TIR) approach is an effective tool for improving STI service quality and creating additional demand for these services; providing STI services, in addition to condoms, to populations who practice high risk behaviors is cost effective; and integrating STI/HIV prevention and control with FP and MCH programs is feasible. There is also a critical need to identify simple, inexpensive surveillance systems for STI/HIV, to support the development of improved female controlled barrier methods, i.e. microbicides and to develop rapid, simple, low cost STD diagnostics for low resource settings.

Condom social marketing (CSM) is an established intervention whose application to distribute condoms for HIV/AIDS prevention has been very successful. The special needs of populations who practice high risk behaviors must continue to be addressed, however, and the existence of supportive societal norms and values make CSM more effective. There is a great need to include female controlled barrier methods in CSM programs as they become available, and gender sensitivity should be considered, when feasible, in condom promotion campaigns.

Lessons learned in **behavior change communication** (BCC) indicate that mass media can quickly raise awareness, and change attitudes and behavior. Mass media is also most effective when coupled with interpersonal communication and community participation/ ownership (peer-to-peer support) which increase the effectiveness of behavior change interventions.

Many of the currently available results in **behavior research** (BR) come from domestic studies but, most likely, could be applied in the international setting. These indicate that HIV/AIDS prevention programs have produced long-term behavior change in specific target populations and recommend several lessons which should be incorporated into future program design.

Addressing policy is essential for effective STI/HIV prevention programs; **policy reform** can create a favorable environment for behavior change, e.g. 100 percent condom brothels in Thailand. A supportive policy environment is also essential to the success of many programmatic interventions, such as allowing youth access to sex education and condoms, allowing nonmedical personnel to provide STD drugs, using syndromic management, or eliminating fees and regulatory obstacles to a wider distribution of STD drugs and condoms.

Monitoring and evaluation and **capacity building** are essential to an effective HIV/AIDS prevention program and should be more fully integrated into the design of country programs and specific interventions.

Likewise, **women's status/empowerment** is a cross-cutting issue that permeates all aspects of any HIV/AIDS prevention programs.

C. Overall Recommendations

This report recommends that USAID incorporate the following proven and promising technical approaches into the Phase III of the ATSP:

1. Strategies

USAID should consider the following strategies:

a) Policy reform at the international donor and country levels—several interventions have been sufficiently field tested and proven effective. USAID could leverage its influence with the other international donors to develop international standards and encourage their adoption and implementation by national governments.

b) Technical Assistance (TA) at the programmatic level to assist clients to design and implement improved programs. USAID should leverage this TA by producing, possibly in collaboration with UNAIDS, a series of "How-to" manuals, guidelines, and case studies demonstrating the most effective design, implementation, and evaluation of these proven interventions.

c) Research focusing on immediate programmatic needs (short-term) and on "scanning" the field, possibly in collaboration with others, to identify promising new developments which would support ATSP, Phase III objectives.

2. Priority Groups

Many prevention efforts to date have effectively focused on groups who practice high risk behaviors and efforts should be continued to reduce HIV transmission through these groups. In the future, however, more effective prevention and control of HIV will also depend upon the expansion of interventions to other groups who are increasingly vulnerable to the virus. The ATSP–Phase III should focus on the following three priority groups:

a) High risk men and women

b) Low-risk women

c) Youth (ages 15-29).[1]

[1] Some research recommends that, to be most effective, AIDS education/prevention programs should begin at ages 9-10.

3. Cross-Cutting Issues

USAID should also consider incorporating two promising approaches into the design of all appropriate interventions in the next ATSP:

a) Gender sensitivity

Phase II research has demonstrated that gender differences affect vulnerability to HIV infection and influence the effectiveness of preventive behaviors. Phase III should both support more research on this topic and design a mechanism to incorporate research results at the programmatic level in a timely fashion.

b) Contextual change

Phase II research has also demonstrated that social structures, social norms, and community values influence individual vulnerability and behavior. The new ATSP should incorporate what is presently known from the HIV/AIDS prevention field as well as the USAID (and other donor) experience from family planning, child survival, and other public health programs.

D. Intervention-Specific Recommendations

The three major ATSP-supported prevention interventions—STD reduction, condom social marketing, and behavior change communication (BCC)—have proven effective in preventing and controlling the transmission of HIV and should remain the focus of the next ATSP. Two of these, condom social marketing and the syndromic approach to STD diagnosis and treatment should be scaled up. While proven BCC interventions should also be scaled-up, this component would benefit from additional research.

To enhance the impact in the three major intervention areas, each of the supporting areas—behavioral research, policy development, monitoring and evaluation, and private voluntary organization (PVO)/nongovernment organization (NGO) support (capacity building)—will continue to be important. To improve the synergy between interventions, USAID should consider redesigning these supporting interventions and improving their coordination of the three major interventions.

E. Future Programming Areas for Consideration

The HIV/AIDS epidemic has established itself worldwide and future prevention and control strategies should consider the needs for 1) linking prevention with care; and 2) building community capacity to respond on the local level.

1. Linking Prevention with Care

As an HIV/AIDS epidemic grows and eventually stabilizes within a given population, the most effective program response also shifts from an initial emphasis on prevention toward a response which integrates prevention with care (See Figure 1, Chapter 1, page 8, "The HIV Prevention to Care Continuum"). In several countries where seroprevalence is high, the present ATSP is supporting several small, community-based demonstrations of social-psychological care and support to HIV positive groups and those living with AIDS. USAID should consider these models in the development of clearly-defined, limited approaches to integrate nonclinical care strategies with prevention during the next phase of the ATSP.

2. Development/Expansion of CBO/Social Mobilization Programs

USAID should also consider the future mechanisms to support the development and expansion of community based organizations (CBOs). Any development in this area, however, must be carefully researched and designed using the experience from other USAID sectors and other donors.

1. Understanding the Global STI/HIV Epidemic and Our Response

A. Magnitude, Distribution, and Trends

In the recent report "USAID Responds to HIV/AIDS," it was noted that worldwide an estimated 10 million men, 7 million women, and 1.5 million children have been infected with HIV, 4.5 million people have developed AIDS, and more than 3 million have died. By the year 2000, an additional 20 million will become infected and an additional 8 million will die of an AIDS-related illness. The vast majority of AIDS cases occur in the developing world, but also occur in deprived populations of the developed world.

In addition, WHO estimates that 333 million new cases of STDs other than HIV occur every year. In developing countries, STDs rank second only to maternal morbidity and mortality as causes of healthy life years lost in women 15 to 44 years of age (World Development Report, Investing in Health, The World Bank 1993).

The populations most affected by HIV/AIDS are also those with high rates of latent TB infections. In healthy individuals who have latent TB infections, approximately 0.2 percent will develop active tuberculosis each year. However, when HIV and TB infection occur together, the activation rate of dormant TB bacillus becomes 8.0 percent, a 40-fold increase. WHO estimates that the number of TB cases will rise from 7.5 million in 1990 to 10.2 million in the year 2000, half of this increase due to HIV/AIDS.

Heterosexual transmission accounts for the vast majority of new HIV infections worldwide. The number of women infected with HIV is increasing rapidly, and in Africa more women than men have become infected. Rising HIV rates in women are accompanied by a corresponding increase in the number of children infected around birth. Over the past decade, infant mortality rates in most developing countries have been reduced to under 100 per thousand births by successful child survival programs. Yet, estimates of infant mortality by the year 2010, taking into account the burden of HIV/AIDS, will put these rates well above 100 per thousand births, and reduce overall life expectancy by 20 to 30 years.

While the HIV epidemic seems to be reaching maturity[2] in many countries in sub-Saharan Africa, other parts of the world, such as Asia, are seeing dramatic increases in new HIV infections. Similar trends are also

[2]An epidemic is considered mature when it reaches a phase in which most infections occur among new cohorts of young people as they become sexually active or engage in any other activity that exposes them to HIV. It is also known as the endemic phase, as opposed to the previous expansive epidemic phase.

emerging in many other countries and/or segments of populations within countries, which up to now seemed to have been spared. Even other African countries, for example South Africa, are seeing explosive HIV epidemics emerge.

Alternatively, some countries, like Chile, where HIV has been present for many years, maintain a stable and relatively low rate of HIV prevalence in the general population (pregnant women, blood donors, etc.). Recent seroprevalence data from Uganda suggest that seroprevalence rates are leveling off and starting to decrease. Uganda has a mature epidemic so these decreasing seroprevalence rates may reflect either a true reduction in HIV incidence or an increased mortality as patients develop AIDS and die, or a combination of both. A careful evaluation of these countries where low HIV prevalence rates in the general population have been maintained over several years or where rates are decreasing, may provide useful information on programmatic, contextual, or other factors that either drive or deter HIV transmission among sexually active populations.

One of the important programmatic areas that should be evaluated is the possible relationship between control of other STDs and stable low rates of HIV infection in some countries. It is known that the spread of HIV is exacerbated by the high prevalence of other STDs, and that early diagnosis and treatment of curable STDs can reduce HIV incidence (Grosskurth H, et al. Lancet, 1995). For example, Chile has had for many decades, a commercial sex workers (CSW) control program which currently screens 20,000 CSWs for STDs. In addition, virtually 100 percent of pregnant women attend antenatal care (ANC) services where routine syphilis screening is provided. STD drugs are provided free-of-charge by the Ministry of Health (MOH) to anyone diagnosed with an STD. HIV prevalence in STD clinics was found to be one percent and among blood donors it was practically zero (Lake E, et al. Abstract, Berlin 1993).

Therefore, the question in addressing the epidemiology of HIV/AIDS is not whether an HIV epidemic will stop increasing, but rather what percent of the general population will be infected by the time HIV/AIDS becomes a mature epidemic? Will it be, for example, in the range of Chile (<1%), Zaire (circa 5%), or Uganda (>20%)? In other words, what will the level of HIV endemicity be once the epidemic has matured? Programmatically the question then becomes: How can we affect the evolution of an emerging HIV epidemic in such a way that the endemicity level will be significantly lower than it would be otherwise, or how can we affect a mature epidemic to lower its current endemicity level?

B. Bridging Epidemiological Paradigms: STI/HIV and Childhood Infections

> In what way has the evolution and dynamics of the HIV epidemic been different from that of other epidemic diseases, particularly those diseases that cause high infant mortality rates?

1. Childhood Infections

Even though there are important differences in the epidemiological patterns of STI/HIV and childhood infections, the basic principles of epidemiology can be consistently applied to both types of infections as well

as to most any other infectious agent. Duration of the infectious period of childhood diseases is typically short and infectivity is usually high, but may vary from one infectious agent to another. Transmission will occur as long as new susceptible individuals can become infected when and if they are exposed to an infectious individual (airborne infections) or source (water/food borne infections). Most adults are either immune or resistant to the majority of childhood infections. Important exceptions are cholera and mutant variants of the influenza virus, which affect adults and children alike. Since the majority of older youth and adults are no longer considered susceptible, most childhood infections must rely on the supply and accumulation of susceptible individuals coming from newborn cohorts in order to survive.

However, most STD/AIDS cases occur in sexually active youth and adults. Children are infected by STI/HIV primarily through perinatal transmission from an infected mother. Childhood infections can be fatal, but usually case fatality is less than 40 percent, whereas HIV has virtually 100 percent case fatality. Most childhood diseases are either airborne or water/food borne in contrast to STI/HIV, which are mostly transmitted through sexual contact.

2. STI/HIV Infections

Unlike childhood infections, the duration of the infectious period of HIV is extremely long (ten years average) and during most of the incubation period infectivity is very low (<0.5%). However, during the first nine to 12 weeks after becoming HIV infected, viral shedding in genital secretions is greatly increased, causing an increase in infectivity during this period.

Studies have also shown that genital infections, such as urethritis and cervicitis, increase viral shedding anywhere from a low of two-fold up to as high as 100-fold and decrease likewise shortly after treatment (Kreiss J, et al. J. Infect. Dis., 1994; Moss G, et al. J. Infect. Dis., 1995; Eron J, et al. JAMA, 1996). One study documented seroconversion rates of HIV in the order of 13 and 56 percent respectively in men who developed urethritis and genital ulcer disease after exposure to CSWs with high rates of HIV infection (Cameron DW, et al., Lancet, 1989). In contrast to the normally low infectivity rate of HIV (<0.5%), these data point to a significant role of other STIs in the spread of HIV by increasing the potential for transmission of persons coinfected with HIV and other STIs.

In addition to the above, other studies have documented a two to 38-fold increase in the number of potential HIV host cells in semen of men with urethritis (Wolff H, Anderson D. Andrologia, 1998), and a two-fold increase in cervical secretions in women with vaginitis and cervicitis (Levine W, et al. Abstract, Yokohama, 1994). These data point to an increased susceptibility to acquiring HIV if exposed to an infected person.

Infectivity is estimated at about one to two percent through contaminated needles and approximately 100 percent through blood transfusion. Perinatal transmission is approximately 30 percent but can be reduced to under ten percent with AZT. Other products, such as vitamin A, are being evaluated to determine if they can reduce perinatal transmission as well.

Transmission will occur as long as new susceptible individuals can become infected when and if they are exposed to infectious individuals (sexual/perinatal) or sources (needles/blood and blood products). Because of its long incubation period, low infectivity rate per exposure; and sexual, parenteral, and perinatal modes

of transmission, HIV epidemics may take several years or even one or two decades to become mature; this is in direct opposition to childhood infections, which become mature in a matter of days, weeks, or months.

When HIV enters a community, it begins to spread among those individuals most easily exposed to its modes of transmission. Those initially infected may become the sources of infection to others exposed to them. From then on this process repeats itself as long as new susceptible individuals can become infected when and if they are exposed to infectious individuals.

As the data from Chile and Uganda suggest, conditions for large-scale transmission of HIV may be very different from one setting to another. A study comparing cervical cancer rates[3] in different settings, revealed marked differences according to different sexual mixing patterns. Pattern I, referred to as "double standard scenario," is characterized by males who are allowed and expected to have multiple sex partners (frequently with CSWs), and by females (housewives) who are expected to maintain monogamy. Pattern II, referred to as "liberal sex scenario," is one in which both men and women are allowed to have multiple sex partners but contacts with CSWs are infrequent. Pattern III, referred to as "puritan type scenario," describes a setting in which rigid social norms dictate monogamy for both males and females. The study found the lowest rates of cervical cancer in Pattern III with the highest rates by far in Pattern I. These findings suggest that the "double standard scenario" increases STI/HIV transmission by favoring infection of large proportions of the sexually active population including those in unilateral monogamous relationships.

It is in such scenarios that the epidemiological construct of populations in situations of "core transmission" becomes critical. Failure to address the prevention and STI care needs of these populations early on in the evolution of an HIV epidemic, can result in one of the most costly "missed opportunities" in modern public health history. Using modeling techniques it has been estimated that treating or preventing 100 cases of syphilis in a high risk core transmission setting would prevent approximately 109 new HIV infections and 4,132 new syphilis infections over a period of ten years (Over M, Piot P. Oxford University Press 1993).

Populations in situations of core transmission can be defined as groups with high HIV infection rates who infect on average two or more individuals per capita. For example, low income women who survive on commercial sex work, must have large numbers of sex partners each day in order to maintain a minimum income to sustain their families and themselves. So when these women become infected, they can infect many people during the nine to 12 weeks of increased infectiousness that occurs shortly after they become infected.

Likewise, groups in situations of core transmission who have frequent and long-lasting episodes of genital infections, during which time infectivity may be increased possibly as much as 100-fold, are particularly important in maintaining high rates of HIV transmission. If on the other hand, those who are being exposed to HIV have genital infections, their risk of acquiring HIV may be increased up to 20 times or more.

In settings where high rates of STIs are found in both groups, e.g., CSWs and their clients, the increased likelihood of transmitting HIV by the former, coupled with the increased susceptibility to acquire HIV by the latter, make the efficiency of HIV transmission skyrocket. It is therefore not surprising that a community-based clinical trial, providing early syndromic diagnosis and treatment for curable STDs over

[3]Cervical cancer is known to be caused by a sexually transmitted agent, the human papilloma virus (HPV).

a two-year period, found that the incidence rate of HIV was on average 42 percent lower in all six intervention communities when compared to the six paired control communities (Grosskurth H, et al. Lancet 1995).

In dealing with HIV and other sexually transmitted infections (STIs), we must address problems related to "stigma" directed against people in situations of core transmission. Stigma may not only block programs aimed at providing needed services, education, and support mechanisms for those living in situations of core transmission, but may in fact increase discrimination against them and create situations even more favorable for STI/HIV transmission.

As an STI/HIV epidemic becomes mature, continued transmission becomes mostly dependent on the supply of new susceptible individuals coming from newborn cohorts as they become sexually active. However, changes in society that affect sexual behavior patterns (social unrest, war, mass displacements, etc.) can inadvertently expose a reservoir of susceptible individuals to STI/HIV that otherwise would not have been. This will send new shock waves of STI/HIV throughout different segments of societies.

Injecting drug use (IDU) can also play an important role in disseminating HIV and other infections, such as hepatitis B virus (HBV), not only among IDUs but also to the general population via sexual transmission. In Argentina for example, an explosive HIV epidemic among young IDUs is jump starting a rapid increase in HIV seroprevalence among pregnant women (Betts C, et al. JAMA 1996—approved for upcoming issue on AIDS). Only recently have alcohol and other noninjecting drugs been recognized as important factors in the risk of exposure to STIs including HIV. These factors induce risk-taking behaviors, exposing people to HIV who otherwise would not have been. This is an area that merits research for future development of strategies and programs addressing these facilitating factors for STI/HIV transmission.

C. Bridging Public Health Paradigms: STI/HIV, Child Survival, and Family Planning

> How do the STI/HIV public health paradigms relate to the public health paradigms that have worked successfully in child survival and family planning?

1. Child Survival Paradigms

Child survival programs have used large-scale vaccination together with simple effective treatment interventions to reduce case fatality of diarrhea, pneumonia and, in some places, malaria. These combined prevention and treatment programs have significantly decreased infant mortality in large segments of the developing world. Eradication of small pox in 1980 and of polio in the Americas in 1995, highlight the success of such programs. Key to successful child survival programs has been policy dialogue to gain social and medical acceptability and social mobilization, to achieve large-scale use of easily administered and very effective medical technologies, i.e., vaccines, antibiotics, and oral rehydration salts.

2. Family Planning Paradigms

The combined effect of rapid reduction of infant mortality rates with lagging high fertility rates (a legacy of the period when infant mortality was extremely high) caused a global population explosion, especially dramatic in the third world. Effective medical technologies have reduced fertility rates and the burden of large families on limited income and unwanted pregnancies in significant segments of the developing world. Policy dialogue has been key for successful family planning programs to gain social acceptability, including deregulating requirements of medical prescriptions for contraceptives, and the development of services for large-scale use of effective medical technologies, i.e., oral contraceptives, intrauterine devices (IUD), and surgical sterilization. The less acceptable condom and the less effective rhythm methods have played relatively small roles in the overall success of family planning programs.

3. STI/HIV Prevention and Control Paradigms

Different stages of an STI/HIV epidemic must be addressed accordingly. The strategic objectives of a program may be different or at least be prioritized differently at various stages of the epidemic. The following two scenarios illustrate this concept:

1) *Settings where sexual mixing patterns create "core transmission scenarios" that favor a large-scale STI/HIV epidemic in the general population, but where HIV is just starting to spread.*

   In these settings, programmatic goals should focus on **reducing the potential for STI/HIV transmission of populations in situations of core transmission**. Implementing these goals would entail aggressive targeted interventions, providing access and appropriate use of condoms, STD treatment, and health education to these groups. During this phase, it is important to monitor the extent of the HIV prevalence in populations in situations of core transmission and the passage of HIV to the general population. This may be done using sentinel HIV surveillance of populations in situations of core transmission, followed with sentinel HIV surveillance in the general population, i.e., pregnant women.

2) *Settings where the HIV epidemic has matured, and most infections occur in new cohorts of sexually active youth and young adults.*

   In these settings, programmatic goals should focus on **reducing the risk of youth-acquired HIV at and around the time that they become sexually active**. Implementing these goals would entail designing aggressive behavior change communication and health education focused on preteens and teenagers through: school curricula and targeted interventions for out-of-school youth; creating a supportive policy environment; assuring youth access to health services; providing adequate STD management; and assuring access to an appropriate supply of condoms. Monitoring STD incidence among youth and young adults (15- to- 24-years-old age group), using sentinel or serial STD or STI incidence/prevalence surveillance systems, would provide a useful surrogate marker for HIV transmission in new sexually active individuals. (Note: Mature epidemics with a high level of endemicity, pose the issue of care for HIV/AIDS-related health problems, including TB (see Figure 1: "The HIV Prevention to Care Continuum").

The programmatic goals highlighted in each scenario are valid for any stage of an STI/HIV epidemic; however, they may be prioritized differently depending on the specific situation. It is common to find in a given time and place various HIV epidemics at different stages of maturation affecting populations that live in the same geographical area. This occurs because the introduction of HIV into different groups may take place at different times, the rate of exposure and transmission via different modes of transmission is variable, and there are different mixing patterns among groups with various levels of risk. Consequently, programmatic responses should be designed accordingly. The same holds true for all other STIs.

4. Integrating Paradigms

The concept of "targeting" interventions, which is key to STI/HIV programs, is also key to child survival and family planning programs. For example, populations in rural areas with high infant mortality rates have been a target/priority of child survival (CS) programs, just as adolescents with high teen pregnancy rates have been a target/priority of family planning (FP) programs. The goal of targeting these populations is to reduce overall infant mortality or unwanted pregnancies while promoting equity and access to services.

In the same way, the goal of targeting populations in situations of core transmission in STI/HIV programs is to reduce overall STI/HIV transmission rates while promoting equity and access among groups. In this case however, targeting situations of core transmission is done not only to benefit those living in situations that are being targeted, but also to reduce the risk of STI/HIV infection in the general population.

From a public health perspective, there is ample reason to address the factors that are creating situations of core transmission. This can be accomplished by developing strategies and mechanisms that help populations at risk to: 1) access appropriate STD services; 2) access an adequate supply of condoms; and 3) access health education for risk reduction and for appropriate use of condoms.

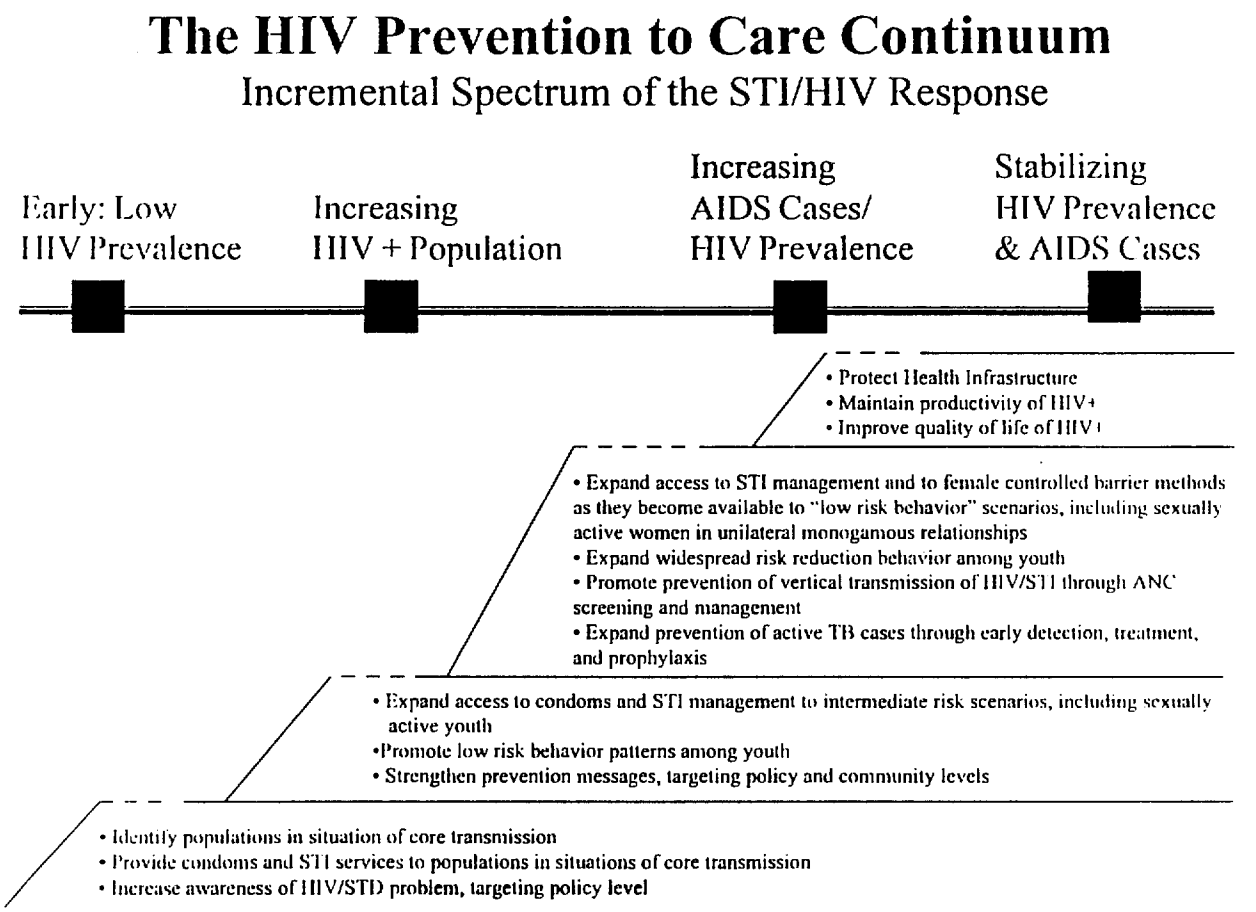
Resistance is frequently encountered when targeting services to benefit populations that are stigmatized as having undesirable behavior. Family planning programs, for example, have had to deal with the stigma associated with providing family planning services to adolescents, because "good teenagers are NOT supposed to be sexually active."

FP programs have gained experience in preventing teen pregnancy which could be used to reduce STI/HIV risk in youth however much more is needed. This is an ideal area for active coordination and collaboration between STI/HIV and FP programs. Both programs could benefit by: 1) developments in behavior change and communication focused on preteens and teenagers; 2) development of school curricula and targeted interventions for out-of-school youth; 3) creating a supportive policy environment; 4) assuring access of youth to health services; and 5) providing adequate STD management and FP services, etc.

Given the accomplishments of child survival programs, there are probably many success stories that could be adapted to STI/HIV prevention and control. One of the useful lessons learned in CS programs is the power and resources that communities can effectively mobilize when working in partnership with programs that improve the health status of the communities. Keys to this lesson are clarity of goals and objectives, a set of well-defined and organized tasks to be executed in a specific timeframe, and personnel designated to execute these tasks.

As HIV epidemics become mature, perinatal transmission of HIV is becoming (just as other STIs already are) a major public health problem to be addressed. Many newborn infections (e.g., congenital syphilis, perinatal hepatitis B, and neonatal tetanus) are preventable, given current available medical technologies. Various studies are looking at measures to reduce perinatal transmission of HIV using AZT, vitamin A, and other products. Coordinating STI/HIV and maternal/child health programs in congenital syphilis elimination and control, for example, could help address the larger issue of STI/HIV in women as well as perinatal transmission of STIs.

Figure 1.



2. ATSP Achievements To Date[4]

USAID has emerged as the global leader in addressing the HIV epidemic, obligating more than $260 million for prevention activities through the ATSP and working to establish global standards of practice for the prevention of HIV. The project has had two distinct phases, beginning with a start-up or learning phase (Phase I) from 1987 to 1991, with two major implementing entities (AIDSCOM and AIDSTECH) and five smaller Cooperating Agency (CA) activities.

In response to the rapid spread of the HIV/AIDS epidemic, USAID redesigned the ATSP in 1991 based upon the lessons learned during the first phase:[5]

- Focus on the most effective interventions: increasing the demand for and access to condoms, partner reduction, and the treatment/control of STDs
- Support NGO/PVO participation through the establishment of an NGO/PVO AIDS Federation
- Establish a communications for behavior change research component
- Scale-up resources and focus on ten to 15 priority countries
- Support the strategic integration of a wide variety of communications approaches to bring about behavior change.

The second phase (Phase II) of the ATSP, which began in 1992 and will terminate in September 1997, has a single major implementing entity (AIDSCAP), and also funds thirteen other CA activities. ATSP activities, under Phase II, have produced numerous achievements in the several program areas.

[4] This chapter draws upon the achievements described in USAID Responds to HIV/AIDS, 1994, pages 14-31. These achievements have been updated to May, 1996 based upon interviews and written materials provided by the Cooperating Agencies.

[5] ATSP Project Authorization Amendment No. 2, pages 8-9

A. Major Interventions

1. STD Reduction

Improving STD control is considered one of the most effective strategies for limiting the spread of HIV/AIDS. Yet throughout the developing world, most people with STDs do not receive appropriate diagnosis and treatment. During Phase II, USAID has provided global leadership in improving STD services in the following areas:

a. Syndromic Approach to STD Management: The further development and promotion of the Syndromic approach to STD management in settings where laboratory services are not available or affordable.

AIDSCAP has demonstrated that STD prevention and treatment is an important public health and policy reform issue. The Project has assisted the following 19 countries to develop national STD guidelines and/or improve care at points of first encounter:

Africa	Asia	Latin America/Caribbean
Cameroon	Thailand	Jamaica
Lesotho	Nepal	Haiti
Ethiopia	Indonesia	Honduras
Malawi	Philippines	Brazil
Senegal		Dominican Republic
Tanzania		
Rwanda		
Kenya		
Zambia		
Morocco		

AIDSCAP has also supported regional STD Management Training Courses in:

Dominican Republic
Senegal
Kenya
Thailand
United Kingdom

AIDSCAP's attempt to promote, through social marketing, the sale of prepackaged STD treatment kits in Cameroon was an innovative approach to expand the availability of syndromic STD management. Lessons learned from this first trial were:

- The Ministry of Health's, the medical community's and the pharmaceutical association's endorsement of syndromic management as a pre-requisite;
- Drugs should be those recommended in the national STD treatment guidelines;
- Local pharmaceutical regulations must be followed; and

- A project advisory committee should be formed and consulted from design through implementation.

These lessons have been applied to the second test of this approach in Nepal. STD syndromic management was officially accepted by the government in 1994 and endorsed by the medical community. The recommended antibiotics for treatment are widely available and affordable. A national advisory committee is participating in the project design.

The Nepal STD prevention social marketing project is currently collecting baseline data. The majority of symptomatic males seek care from pharmacists. Survey results indicated that while 81% of chemists suggest medications to treat urethritis, less than 1% recommend the correct medication and dosage. In addition, only 14% recommend condom use and 5% suggest partner referral for STD treatment.

b. Improved STD Diagnostics: The STD Diagnostics Initiative (SDI) is sponsored by USAID and other donors with a secretariat at UNAIDS. Until 1994, this program, which aims to identify or develop affordable diagnostic tools appropriate for limited resource settings, was implemented by the Program for Appropriate Technology in Health (PATH). PATH now receives direct funding from the ATSP to continue this work as a "participating center" for the SDI.

To date, PATH has developed a field culture test for gonorrhea and a simplified method for syphilis determination which is currently commercially available through a private firm in the United Kingdom. PATH also continues to work on rapid "dip stick" tests for gonorrhea and chlamydia using non-intrusive specimens such as urine.

c. Target Intervention Research (TIR) Methodology: AIDSCAP has developed and field-tested the Target Intervention Research (TIR) methodology, an approach which uses qualitative research of current STD health seeking behavior to improve the quality of STD services.

AIDSCAP has supported TIR studies in Senegal, Ethiopia, Republic of South Africa, Morocco, Malawi, Benin, Swaziland, Zambia, and the Philippines and has published a manual, a collaborative product of the STD, Evaluation, BCC, and Behavioral Research Units, to promote the wide spread application of this approach. TIR studies, funded by WHO/GPA and the European Community, have been carried out in China and Nepal.

In Ethiopia, TIR results were presented during a six-day IEC materials development workshop. Key points included respondents' perceptions that government clinics had inadequate diagnostic capabilities, health care workers at government facilities were rude, and women disliked the lack of privacy in the examination rooms. Based upon these results, material designers identified 33 topics to be addressed during the development of STD prevention materials targeted to clinic users.

A TIR study conducted in Zambia found a great disparity between local language and biomedical terms for STDs. Based upon this information all peer education and local media were designed not to list names of STDs but rather to describe signs and symptoms.

Results from a TIR study in Senegal indicate that issues of confidentiality are major determinants of health seeking behavior. Patients will travel great distances away from their communities to receive services, seek care of retired health care providers or health workers at their homes after clinic hours,

or go directly to pharmacies. Also, as in Zambia, there is a great disparity between local language and biomedical terms for STDs. These findings will be considered in designing improved STD services.

d. Improved, Cost Effective STD Interventions: AIDSCAP has demonstrated global leadership in the continued development and promotion of improved, cost-effective STD interventions by:

- Publishing more than 16 articles on STDs in refereed journals
- Conducting 16 STD-related research studies in 13 countries
- Presenting more than 40 abstracts at international and regional conferences

2. Condom Social Marketing

Consistent condom use can greatly reduce the spread of HIV. The ATSP, through AIDSCAP, implemented a full range of condom programming initiatives: the acquisition of condoms from sources other than USAID, increased distribution of condoms ensuring accessibility to vulnerable populations, and the promotion of condoms, including both the benefits of condom use and the necessity for correct and consistent use.

a. Condom Distribution: AIDSCAP[6] has substantially increased condom distribution for HIV/AIDS prevention. Over the life of the project, AIDSCAP has distributed the following totals by region:

Africa	120,783,034
Latin America/Caribbean	77,302,714
Asia	17,490,872
Total	215,576,620

Eighty-five percent of these condoms have been distributed though social marketing programs.

On an annual basis, the number of condoms distributed by AIDSCAP has grown dramatically—from one million in 1992 to over 73 million in 1995. AIDSCAP projects that distribution will exceed 91 million for 1996 (See Figure 3).

[6] These social marketing programs have been implemented through Population Services International (PSI), a subcontractor on AIDSCAP.

Figure 2.

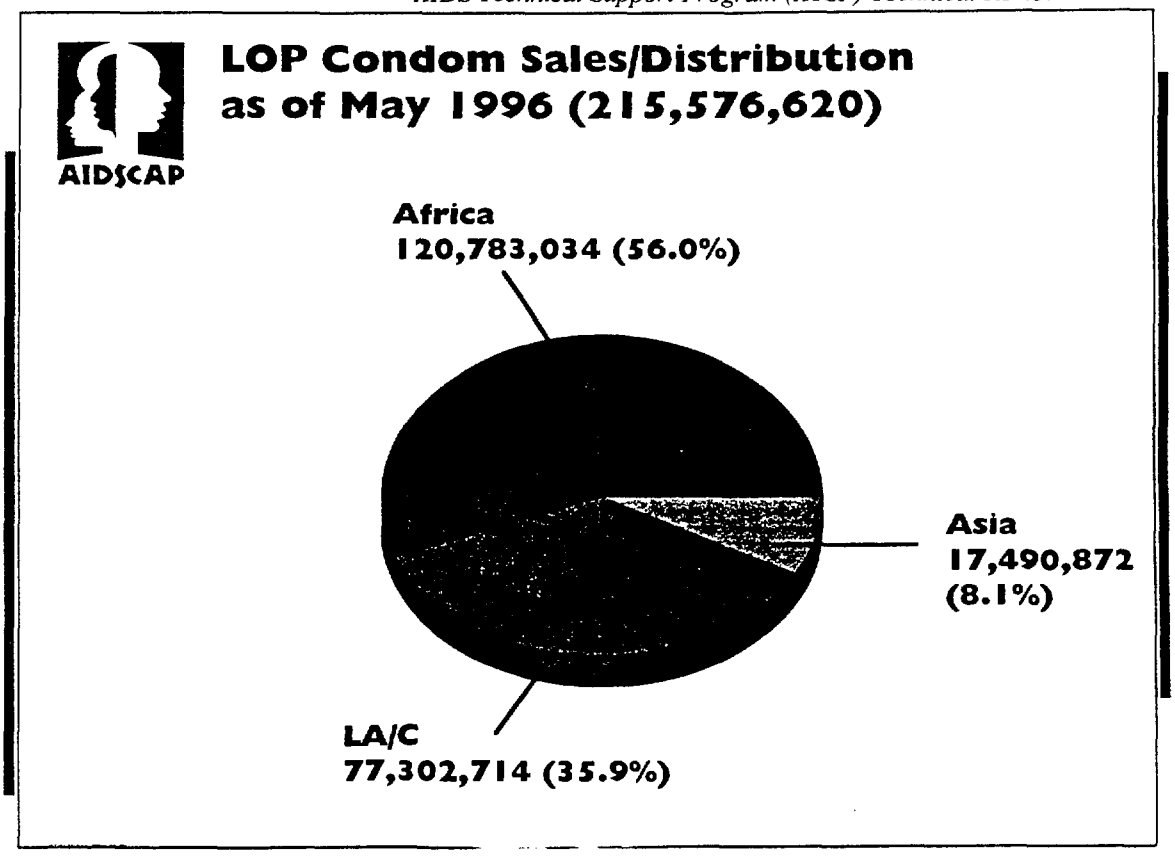
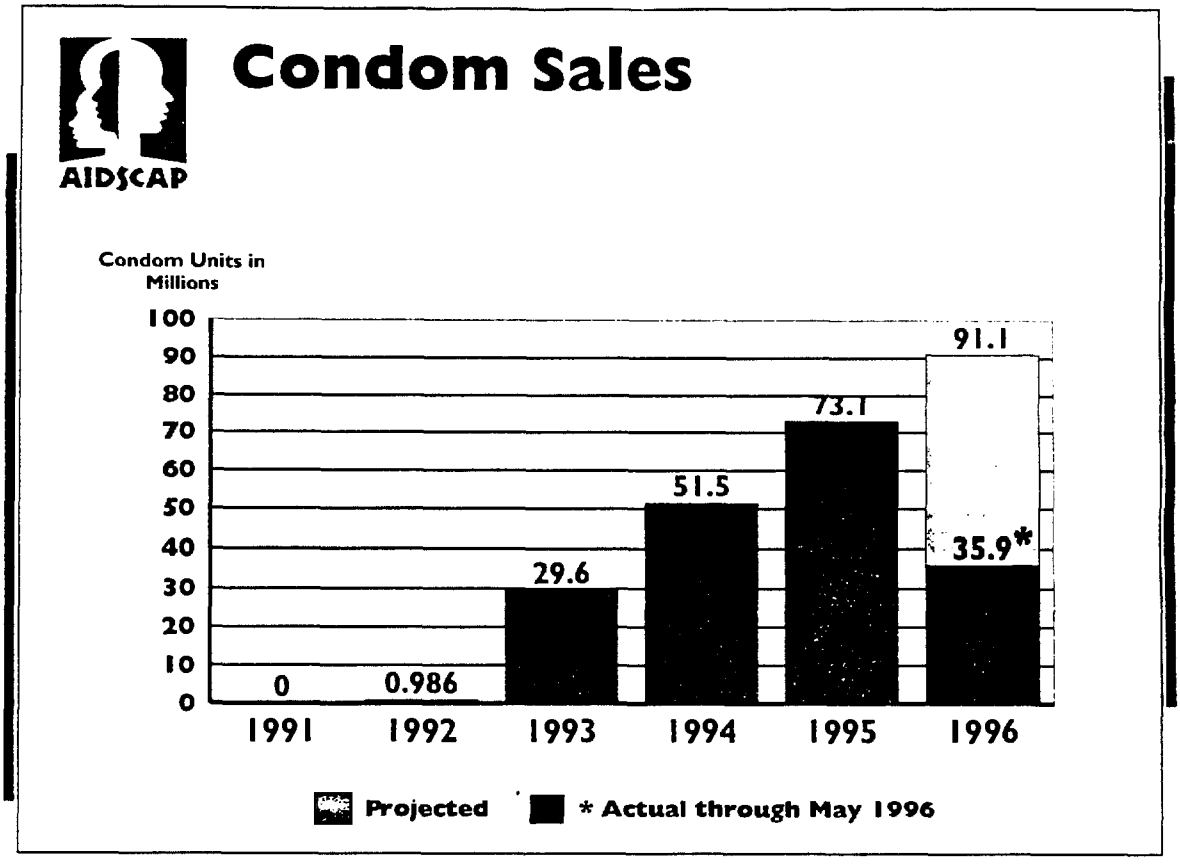


Figure 3.



b. Leveraging: AIDSCAP has leveraged other sources to provide condoms in countries with USAID-initiated condom social marketing programs. PSI estimates that during the life of AIDSCAP it will leverage an additional $2 for very $1 that AIDSCAP will invest in the eight countries that received significant task orders for social marketing.[7]

c. Policy Dialogue: AIDSCAP influenced the Brazilian government to reduce tariffs on condoms totaling 35%. The elimination of this tariff reduced the cost of condoms by $1.99 per gross. This effort reduced condom prices in Brazil and greatly increased demand, resulting in a dramatic increase in the commercial market for condoms

3. Behavior Change Communication

Behavior research has taught us that knowledge of the basic facts about AIDS is not sufficient to change behavior. Through the ATSP, USAID has served as a catalyst in moving HIV/AIDS prevention programs from providing basic information about transmission to designing communication strategies to influence individual behavior and social norms. In the field, ATSP supported programs have demonstrated the effectiveness of combining mass media with interpersonal communication and using peer educators.

a. Global Leadership: AIDSCAP has provided global leadership in the development and promotion of improved BCC interventions through the following activities:

- The BCC database containing 450 AIDSCAP IEC materials from 20 countries
- Technical support to 195 BCC projects in 26 countries
- Development/dissemination of the following "how-to" manuals:
  - Assessment and Monitoring of BCC Intervention
  - How to Create an Effective Communication Project
  - Behavior Change through Mass Communication
  - How to Create Effective Pretests
  - How to Create an Effective Peer Education Project
- Conducted a major peer education study to identify factors critical to success

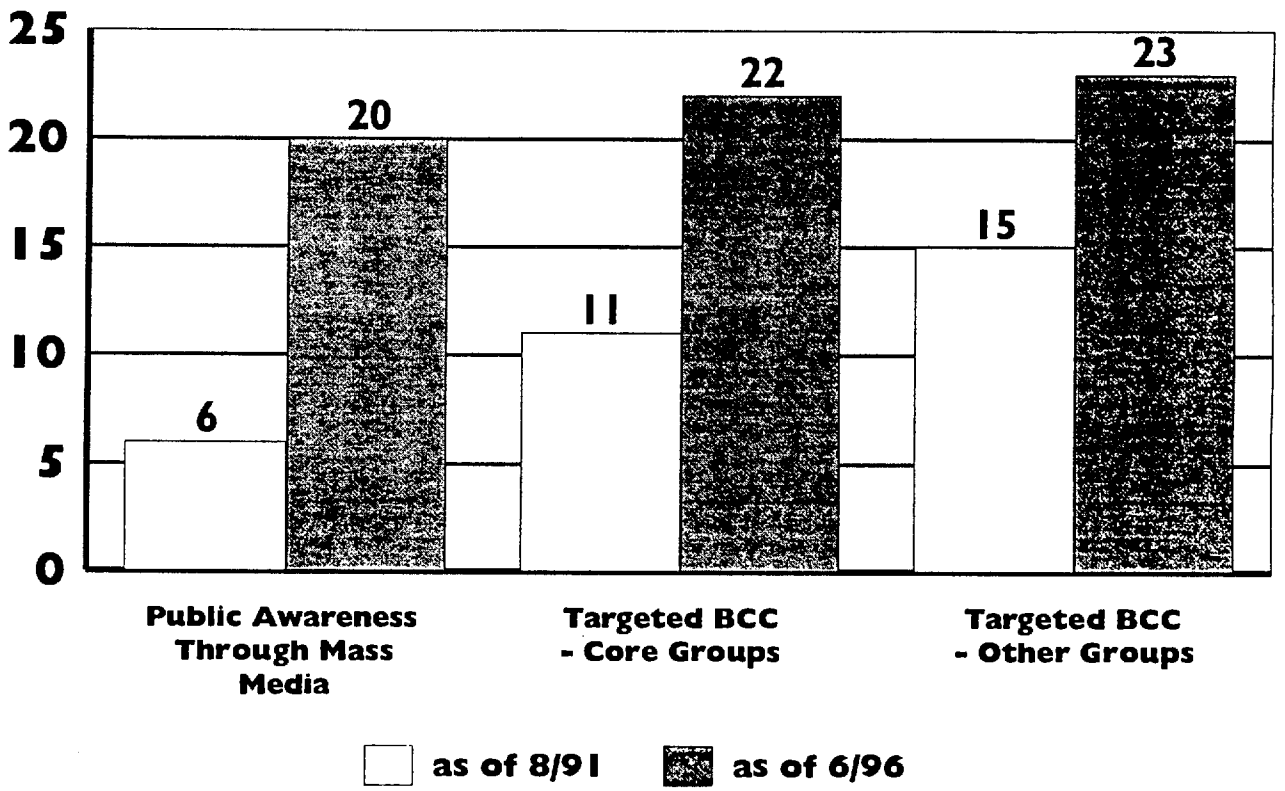
b. Results: AIDSCAP's efforts to incorporate BCC strategies into national AIDS prevention plans have resulted in the following increases between 1991 and 1996:

- An increase from six countries to 20 countries with Public Awareness Campaigns through mass media;
- An increase from 11 countries to 22 countries with BCC strategies targeted toward groups who practice high risk behaviors; and
- An increase from 15 countries to 23 countries with BCC strategies targeted toward other groups (students, youth, women, etc.).

[7] Rwanda, Tanzania, South Africa, Haiti, Cameroon, Lesotho, Brazil, and Ethiopia.

AIDSCAP

Number of countries with USAID-Supported STD/HIV communication strategies



In Nepal, AIDSCAP designed a set of mutually-reinforcing interventions to reduce the transmission of HIV between commercial sex workers and their clients. This outreach project improved access to STD services, increased the use of condoms, and reduced risk behaviors through targeted behavior change communication and outreach education. The BCC outreach component is the core which links all of the other prevention components and services into an integrated program for the target communities.

AIDSCAP developed an integrated BCC strategy in Tanzania to target adolescents and sexually active adults. Formative research indicated that young people lacked a reliable source of information about HIV/AIDS and that both young people and older adults responded well to mass media approaches. In response AIDSCAP developed one magazine, "Straight Talk," for adolescents and a second, "Tuzungumze," for adults. Both publications have become important sources of information on HIV/AIDS prevention for their respective national audiences.

B. Supporting Interventions

1. Behavioral Research

Understanding why people engage in behavior that places them at risk of HIV infection is the first step toward helping them change that behavior.

a. Global Leadership: AIDSCAP has provided global leadership by collaborating with UNAIDS to conduct a multi-country study on the role of voluntary HIV counseling and testing in prevention.

HIV counseling can play a variety of roles beyond the minimum requirement that people understand and consent to an HIV test. Training and employing counselors, however, is expensive, so it is important to develop low-cost models that promote appropriate behavior change. This controlled study will provide information that can help guide public health practice and policy. AIDSCAP is funding work in Kenya and Tanzania; while UNAIDS will support parallel studies in Indonesia and Trinidad.

b. Increased Knowledge Base: AIDSCAP has contributed to the scientific knowledge of HIV prevention through the publication of 40 behavioral research articles in peer-reviewed literature and the presentation of 45 papers at scientific conferences.

c. Technical Assistance: AIDSCAP has provided technical assistance for country-specific behavioral research projects in 14 countries.

A study in Nicaragua used focus groups and key informant interviews to examine the underlying factors for behavior that places commercial sex workers (CSWs) and men who have sex with men at risk. Results revealed that even though knowledge of HIV/AIDS was high among both groups, condoms were rarely used. CSWs had positive attitudes toward condoms but their lack of power in

sexual transactions forced them into risk taking. Interventions have been designed to improve the acceptability of condoms among clients and develop sexual negotiation skills among CSWs.

A risk assessment among 1,667 new military recruits in Thailand revealed considerable risk for HIV through the frequent use of CSWs. A multi-faceted intervention based upon the principles of social influence, participation, and diffusion theory, as well as informal friendship networks among conscripts, produced statistically significant reductions in unprotected sex with girlfriends, fewer visits to CSWs, and increased condom use with CSWs.

In Uganda, qualitative interviews with 443 individuals presenting at a counseling and testing center examined whether knowledge of HIV status led to behavior change. Findings revealed that returning for test results and post-test counseling did not predict risk reduction strategy at follow-up. Being HIV positive was a predictor of abstinence but not condom use. Interestingly, individuals who did not return for post-test results were most likely to be HIV positive males, revealing that in this context, male seropositives remain a high risk group which is difficult to reach.

2. Involving Women

To make HIV/AIDS prevention interventions more relevant for women, the ATSP has supported research to gain a better understanding of the factors that affect women's risk of infection, develop more effective methods for reducing HIV among women, and integrate HIV/AIDS prevention into family planning and maternal child health programs.

a. Research: The International Center for Research on Women (ICRW) is conducting research into the behavioral, sociocultural, and economic factors that influence women's vulnerability to HIV and opportunities for reducing their risk.

Seventeen, first-round research projects have yielded important insights into the realities of women's lives and have resulted in a set of policy and program recommendations. The ATSP has also funded eight, second-round projects to give research teams the opportunity to implement intervention strategies identified during the first round and evaluate their impact at the community level.

b. Advocacy: AIDSCAP has organized the Women's Initiative to strengthen HIV/AIDS prevention efforts for women in developing countries, including:

- The incorporation of gender into 29 activities, including model projects into priority country programs;
- The development of a training module to improve gender attitudes and programming skills among program managers and policy makers; and
- The development of a database which identifies how women and girls are targeted in sub-projects.

c. Female-controlled Barrier Methods: The ATSP is supporting the development of women-controlled barrier methods in the following ways:

- AIDSCAP is testing the acceptability of the female condom in studies in Kenya and Brazil
  - Preliminary results from Kenya indicate that most women in the study like the device and voice few complaints. The male partners in this study also accepted the device.
- The Population Council is working to develop a non-contracepting microbicide

d. Pilot Studies: The International Planned Parenthood Federation (IPPF/WHR) has completed a study to test the feasibility of integrating STD/HIV prevention into family planning programs.

The initial results from this pilot test, conducted in Jamaica, Brazil, and Honduras are very promising. A final program evaluation will be available by August 1996.

3. Promoting Policy Dialogue

Throughout the world, progress in slowing the HIV/AIDS epidemic is threatened by social, cultural, economic, and regulatory barriers to prevention. The ATSP supports policy dialogue and reform at the international, country, and local levels, and in the public and private sectors to create an environment where HIV prevention programs can operate effectively and efficiently.

a. Improved Methodologies: AIDSCAP has improved methodologies to influence policy makers about the serious economic and social impacts of the HIV/AIDS epidemic by:

- Identifying the specific impacts of the HIV/AIDS epidemic that will most effectively inform, sensitize, and motivate various groups of policy makers (i.e., economic impacts presented to senior finance ministry officials);
- Expanding the scope of socioeconomic impact assessments to include impacts on women, households, and specific economic sectors; and
- Supporting the development of local advocacy networks to influence policy reform.

b. Private Sector Advocacy: AIDSCAP has developed and published "Private Sector AIDS Policy: Business Managing AIDS."

The "Private Sector AIDS Policy" materials raise the awareness of business leaders of the need to promote HIV/AIDS prevention policies and programs in the workplace by assessing the economic costs of the HIV/AIDS epidemic to specific businesses. This approach has been used in Nigeria, Kenya, and Senegal.

c. International Network Development: The National Council for International Health (NCIH) has developed an international network of over 600 NGOs (half U.S.-based, half developing world) who support policy reforms at the international and national levels through advocacy and information dissemination. NCIH publishes and distributes a bi-monthly newsletter, responds to 200 information requests each month, and manages a small grants program for community based organizations (CBOs).

4. Monitoring and Evaluation

Monitoring and evaluation are critical to ensuring that ATSP resources are used effectively and that they achieve results.

a. Indicators Development: AIDSCAP has provided global leadership by collaborating with WHO/GPA to establish a set of standardized Prevention Indicators (PIs) what can be used worldwide.

This list of ten PIs measure target audiences' knowledge, condom availability, use of condoms and other reported changes in sexual behavior, the quality of STD case management, and the prevalence of specific STDs and HIV. While these PIs were developed for use with general populations, AIDSCAP has incorporated them into their evaluation designs and adopted them for use with target groups, particularly those indicators that relate to high risk sexual behavior and are collected through Knowledge, Attitude, Practice and Behavior (KAPB) surveys (PIs 1, 4, 5 and 9)[8]

AIDSCAP is also involved in testing PIs 6 and 7[9], the indicators for evaluation of STD case management through health facility assessments, in Malawi, Jamaica, Honduras, and Ethiopia. Baseline data was collected in previous years and follow-up data collection is planned.

b. Behavioral Surveillance: AIDSCAP developed the Behavioral Surveillance Survey (BSS).

This innovative methodology tracks trends in behavioral indicators among key target groups that are the focus of multifaceted and overlapping interventions and thus can monitor the effects of prevention programs at the regional level. BSS is being used in Thailand and is being field tested in Senegal, India, and Indonesia.

c. Tools Development: AIDSCAP has produced tools in two categories: 1) Evaluation tools; and 2) Planning tools.

i. Evaluation Tools: AIDSCAP has produced four manuals in the Evaluation Tools Modules series. The four—which include AIDCAP's Evaluation Strategy, Use of Focus Group

[8] PI1: Knowledge of Preventive Practices; PI4: Reported Non-Regular Sexual Partners; PI5: Reported Condom Use with Non-Regular Sex Partners; PI9: Reported STD Incidence, Men.

[9] PI6: STD Case Management/Percentage of individuals presenting with an STD who are treated in an appropriate way (according to national standards); PI7: STD Case Management/Percentage of individuals presenting with an STD who receive basic advice on condoms and partner notification.

Discussions, Incorporating Evaluation into Project Design, and Applying the Behavioral Surveillance Survey—have been reprinted, translated, and widely distributed.

ii. Planning Tools: AIDSCAP has developed the AVERT model. This model serves as a planning tool for stakeholders and project managers to examine the impact of HIV prevention programs in terms of the number of HIV infections averted. The model is currently undergoing final testing and will be distributed to the field in early 1997.

d. Data Dissemination: The U.S. Bureau of the Census (BuCen) has established a global leadership position in the collection and distribution of HIV surveillance data. The BuCen seroprevalence database has made it possible to follow trends in the epidemic in many parts of the world. This data is used to report the status of the epidemic in the official publications of many international organizations including WHO, Pan American Health Organization (PAHO), United Nations Children's Fund (UNICEF), United Nations Development Programme (UNDP), and the World Bank.

5. Building Community Capacity

Sustained behavior change depends upon community involvement. Over the past decade NGOs have demonstrated that they are in the best position to mobilize communities for HIV/AIDS prevention and care.

a. NGO Support: The International HIV/AIDS Alliance has established NGO support programs in seven countries; five more country programs are currently under development.

The Alliance first works with the existing NGO/CBO community to establish a "linking organization" in each country which will then represent these local organizations to the Alliance. The Alliance provides funding and technical assistance to the "linking organization" to build institutional capacity. The "linking organization", in turn, provides funding, technical expertise, and training to local NGOs and CBOs to establish HIV/AIDS prevention programs. This approach appears to be an effective mechanism to transfer donor resources to the local the level; the Alliance estimates that 86% of its 1996 budget will be allocated to technical assistance and funding for local programs. The program is also effective in expanding HIV/AIDS prevention programs through established NGO/CBO networks. Two hundred of the 220 organizations who have received Alliance support to date were already providing other (non HIV/AIDS related) services to their communities.

b. Innovative Grants Program: AIDSCAP has supported the development of NGO and CBOs through Rapid Response grants and a PVO Competitive Grant Program.

The Rapid Response grants were used to pilot test the feasibility of expanding community-level projects, support specific issues important to local groups, and encourage implementation of innovative ideas for AIDS prevention. The PVO Competitive Grant Program funded nine programs which incorporated HIV/AIDS prevention components into already-established organizations.

c. Skills Building: AIDSCAP developed a successful model to improve the proposal development skills and involve organizations in program design in four stages:

i. Provide initial training
ii. Participants develop their draft proposal
iii. Review/revise draft
iv. Revised proposal approved/funds allocated for implementation.

d. Supporting Community Responses: The Peace Corps PASA (Participating Agency Service Agreeement) has supported the design and implementation of community level programs targeting hard-to-reach groups such as out of school youth, commercial sex workers, and the residents of small rural communities.

In Cameroon, education volunteers and their counterparts have developed a curriculum, "Teach English, Prevent AIDS," that incorporates HIV/AIDS prevention into their English classes. Over 180 Cameroonian teachers have been trained to use this curriculum, reaching approximately 10,800 students per year. The curriculum has been adopted in a number of countries including Central African Republic, Gabon, Togo, and Chad.

3. Lessons Learned and Unmet Needs

This chapter presents lessons learned and promising areas of technical development with regard to STI/HIV prevention and control in the basic intervention and supporting intervention areas of the current ATSP. These include respectively, STD/CSM/BCC and behavior research, policy reform, monitoring and evaluation, capacity building, and women's status/empowerment. The technical lessons learned, unmet needs, and resulting recommendations for each of the above interventions are summarized in matrix format in the following pages.

In the area of STD/STI reduction, experience from the field demonstrates that syndromic management is an effective approach to diagnosis and treatment of symptomatic STIs in resource poor settings; sufficient supplies of STI drugs are critical for effective STI programs; the TIR approach is an effective tool for improving STI services quality and creating additional demand for these services; providing STI services, in addition to condoms, to high risk populations is cost effective; and integrating STI/HIV prevention and control with FP and MCH programs is feasible. There is also a critical need to develop rapid, simple, STI diagnostics and inexpensive surveillance systems for STI/HIV and to support the development of improved female controlled barrier methods, i.e., microbicides.

Condom social marketing is an established intervention and the use of social marketing techniques to distribute condoms for HIV/AIDS prevention has been successful. Special needs of high-risk populations must continue to be addressed, and the existence of supportive societal norms and values make CSM more effective. There is a need to include female controlled barrier methods in CSM programs as they become available and gender sensitivity should be considered, when feasible, in condom promotion campaigns.

Lessons learned in behavior change communication (BCC) indicate that mass media can quickly raise awareness and change attitudes and behavior. Mass media is also most effective, when coupled with interpersonal communication and community participation/ownership (peer-to-peer support), in increasing the effectiveness of behavior change interventions.

Many of the currently available results in behavior research (BR) come from domestic studies but most likely could be applied in the international setting. These results indicate that HIV/AIDS prevention programs have produced long-term behavior change in specific target populations, and recommend several lessons which should be incorporated into future program design. For example, many interventions are more effective in reducing risk taking behaviors of non-sexually active youth than of sexually active youth and sustained interventions which also modify environmental factors can lead to sustained behavior change.

Addressing policy is essential for effective STI/HIV prevention programs; policy reform can create a favorable environment for behavior change, e.g., 100 percent condom brothels in Thailand. A supportive policy environment is also essential to the success of many programmatic interventions, such as allowing youth access to sex education and condoms, allowing nonmedical personnel to provide STD drugs, using syndromic management, or eliminating fees and regulatory obstacles to a wider distribution of STD drugs and condoms.

Approaches to the monitoring and evaluation of HIV/AIDS interventions continue to be refined and improved. A Monitoring and Evaluation (M&E) plan should be designed into each national HIV/AIDS prevention strategy and all stakeholders (national government, NGO, and mission) should agree to the costs and timelines for implementation and the results which will be produced. The Global Bureau and missions should also agree on their respective responsibilities for the funding and management of specific activities under this plan. The ATSP has developed several simple, cost-effective M&E methodologies, including the Behavioral Surveillance Survey (BSS), which should be more-widely applied in the future. Finally, the development of a simple, low-cost HIV/STD sentinel surveillance system is critical to planning and managing ongoing country level programs.

The development (capacity building) of NGOs/PVOs/CBOs is essential to sustain and expand the reach of effective HIV/AIDS prevention programs and should be more fully integrated into the design of country programs and specific interventions. Capacity building, other than ad hoc technical skills transfer, will require addition resources and, more importantly, investment in staff with specialized skills and experience in conducting organizational assessments and implementing longer-term organizational development/ strengthening plans.

Likewise, women's status/empowerment is a cross-cutting issue that permeates all aspects of HIV/AIDS prevention programs. Males and females should always be considered as separate target groups in the design and implementation of research and programmatic interventions.

STD/STI REDUCTION
TECHNICAL LESSONS LEARNED, UNMET NEEDS, AND RECOMMENDATIONS

TECHNICAL LESSONS LEARNED	UNMET NEEDS	RECOMMENDATIONS
1. Syndromic management is highly sensitive, specific, and cost effective in symptomatic men with urethritis, men and women with genital ulcer disease, and women attending STD clinics or in places with high STD prevalence who present vaginal discharge.	Other than currently available rapid tests for syphilis, there is an acute need for simple, inexpensive, accurate tests for detecting STIs in asymptomatic individuals who will not be treated using the syndromic management approach and symptomatic low risk females.	1.1 Continue promoting, at policy and advocacy levels, the acceptance and adoption of syndromic management as a standard practice in primary health care services. 1.2 Give high priority and scale up research for the development of simple, inexpensive, accurate tests for detecting STIs, particularly chlamydia and gonorrhea, in asymptomatic individuals and symptomatic low risk females. 1.3 Scale up promotion, at policy and advocacy levels, use of rapid syphilis tests (i.e. RPR, TRUST, etc.) in family planning (FP) and antenatal care (ANC) services.
2. TIR has proven to be an effective tool to improve clinical services for the detection, treatment, and comprehensive management of STDs, including the "4 C's" (counseling, condoms, compliance, and contacts) .	There is a need to study health seeking behavior, including populations who currently utilize formal clinic services, as those who do not.	2.1 Scale up development and field testing of tools to assess health seeking behavior in communities that do not normally seek formal clinic services for management of STD related syndromes.
3. Providing high risk populations, particularly commercial sex workers (CSWs) and their clients, with services for the detection, treatment, and comprehensive (4 C's) management of STDs, has proven to be cost effective, even when screening with diagnostic tests that are costly, but accurate, are used (Sanchez/Holmes, Peru study, unpublished data). NOTE: The effectiveness of this approach would increase greatly if or when simple, inexpensive and accurate tests for gonorrhea and chlamydia are developed and become widely available.	Targeting high transmitter groups is most effective in high risk/urban populations, where short distances and laboratory infrastructure usually make this approach feasible. Similar targeting approaches in settings where sexual "mixing" patterns are different from the classical "core group" model may be less effective, yet validation studies are needed on this matter.	3.1 Continue promoting acceptance, at policy and advocacy levels, for providing services targeted at high risk populations, particularly CSWs and their clients, that include detection, treatment, and comprehensive (4 C's) management of STDs. 3.2 Validate the effectiveness of targeted interventions in settings with different sexual behavior "mixing" patterns and different legal/social status of CSWs.

TECHNICAL LESSONS LEARNED	UNMET NEEDS	RECOMMENDATIONS
4. The integration of STD/HIV prevention and control with MCH and FP services has the potential to reach large numbers of low risk sexually active females. According to IPPF/WHR, an STD/HIV prevention and control program has been successfully integrated into existing FP clinics in Brazil, Honduras, and Jamaica	Complete the (currently ongoing) evaluation of the IPPF/WHR pilot STD/HIV/FP integration project. Other than currently available rapid tests for syphilis (RPR, TRUST), there is an acute need for simple, inexpensive, accurate tests for detecting STIs in low risk settings, such as MCH and FP services. However, even available syphilis tests have been used on a very limited scale in FP services and there is significant room for improvement in prenatal care services (i.e., PAHO's 1995 resolution on elimination of congenital syphilis as a public health problem in the Americas). Youth are not being reached with MCH, FP, or STD services. Integrated reproductive health services that are tailored for youth are sorely needed and should be priority.	4.1 If successful, scale-up the IPPF/WHR pilot STD/HIV/FP integration project to include the entire region. Study the feasibility of expanding the program to the other IPPF regions. 4.2 Integration of STD/HIV prevention and control with MCH and FP services is a promising area that needs more attention, focusing on factors which may either facilitate or hinder the effectiveness of integrating these services. These may include: - Development of simple, inexpensive, accurate and available tests to detect STIs. - Improve and field test "risk profile assessments" as an alternative for detecting STD/STIs among females in low risk settings. - Identifying obstacles to expand syphilis testing in family planning clinics and prenatal care services.
5. Female controlled "barrier" methods will greatly increase women's' ability to protect themselves against STDs and HIV.	There is an urgent need for female controlled "barrier methods" because: - Women are most vulnerable and most severely affected by STD/STIs and their complications. - The most effective currently available technical interventions (STD detection and treatment, partner reduction, and condoms) are most appropriate and more easily controllable by men, rather than by women.	5.1 Female controlled "barrier" methods are a very promising area that should receive high priority. Technological developments are occurring very rapidly and include products in the initial phase of development, i.e., noncontraceptive microbicide (Population Council), efficacy trials, i.e., N-9 based microbicide (NIAID/NIH), all the way to products being field tested for acceptability/affordability, i.e., female condom (AIDSCAP).

TECHNICAL LESSONS LEARNED	UNMET NEEDS	RECOMMENDATIONS
6. A critical limiting factor to the expansion of effective STD control is the current lack of appropriate STD drugs.	Unless effective STD drugs are available, most other efforts will not go very far: including promotion of syndromic management, using TIR to improve clinical services, targeting high risk populations, integrating STD/FP/MCH services, developing and implementing monitoring and evaluations methods, etc.	6.1 Mechanisms to overcome lack of STD drugs should receive the highest priority in policy development and advocacy in: addressing country commitment and donor coordination, including STD drugs in national basic drug lists, procurement at national and international levels, as well as developing social marketing approaches, for example, STD drug kits in settings where antibiotics are available "over the counter" and the medical associations are supportive.
7. Current STD surveillance systems, based on universal reporting of STDs, provide little or no useful information on STD incidence and prevalence in most developing countries.	There is an acute need to have a better understanding of the distribution and trends of STD/STIs, in order to develop reasonable estimates for policy and advocacy, as well as for program design and monitoring.	7.1 Replace or adjust current universal STD case reporting systems with a simplified Serial Prevalence/Incidence Monitoring System which can provide, at reasonable cost, useful information on STD incidence and prevalence, even in places with limited health infrastructure.

STD Reduction

Recommended USAID Interventions at the Service Delivery level

Target Groups	Intervention(s)
High Risk	
• Male →	Promote: (1) Syndromic mgmt., counseling, condoms, contacts, and compliance (2) TIR Methodology and IE&C to increase demand (3) Social Marketing STD kits
• Female →	Promote: (1) Service access/screening, counseling, condoms, and compliance Research: (1) Development of new diagnostics
Low Risk	
• Male →	Promote: (1) Syndromic mgmt., counseling, condoms, contacts, and compliance
• Female →	Promote: (1) Screening for Syphilis (2) STD/HIV/MCH/FP service integration Research: (1) Development of new diagnostics (2) Acceptability of female condoms (3) Development and field testing of Microbicide (s) (4) Improve and validate "risk profile assessments" and other methods for detection of STIs.

Supporting Components

- •Policy Dialogue: Promote National Guidelines
- •Capacity Building in Program Mgmt.
- •Develop Serial Prevalence Monitoring System
- •Provision of Adequate STD Drug Supply
- •Provision of Adequate Condom Supply

CONDOM SOCIAL MARKETING

LESSON LEARNED	UNMET NEEDS	RECOMMENDATIONS
1. The application of social marketing to distribute condoms for STD/HIV prevention has been extremely successful.	Increase the supply of condoms; sales are presently limited by the supply.	This issue should receive the highest priority in policy development and advocacy, addressing country commitment and donor coordination including: - Establishment of a multi-country "bulk" purchasing system, with a multilateral or country level commitment to pay part/all of the cost. - Donor coordination at the country level to assure a sufficient supply to meet program needs. - "Front-load" country programs over 2-3 years ("Revolving Condom Supply Approach") the income can sustain the supply of condoms and profits may finance expansion.
2. Condom social marketing programs are more effective than public sector programs.	None.	Continue to invest most resources in SM rather than public programs.
3. Social marketing to marginalized target groups is more costly than marketing to the general population, however, some country programs can recover the cost of condoms and become selfsufficient in commodity supply.	Maximize cost recovery.	Operations research to develop the most cost-effective marketing systems selfsufficiency.
4. Social marketing is more effective when societal norms and values support (i.e., destigmatize) condom use.	Increased emphasis on supporting change in societal norms and values related to condom use.	Incorporate into country level planning a strategy to influence societal norms/values (contextual factors) into each AIDS prevention/control program.
5. Condom social marketing is principally targeted to men.	Campaigns targeted toward women.	Promising: Area for Additional Research - Would this be a cost-effective intervention to develop a complimentary social marketing campaigns for women which: - In addition to "normal" communication channels, utilizes women-specific communication networks. - Promotes positive messages which support women's self-esteem and their right to control their sexuality. - Develops trademarks and packaging targeted to women. - Supplements the present network of retail outlets with locations where women will be "comfortable" in purchasing the product.

LESSON LEARNED	UNMET NEEDS	RECOMMENDATIONS
6. Social marketing campaigns should promote gender sensitive values and social norms which are not detrimental to women .	Messages are needed which promote positive or, at least, neutral values toward women.	Conduct research to determine if gender positive/neutral messages can effectively promote condom purchase and use to targeted subgroups of men.
7. Reductions in tariffs for condoms can reduce retail prices and stimulate demand both in the commercial and social marketing sectors.	Elimination of tariffs on condoms.	For the future, promote the elimination of tariffs.
8. Special marketing strategies can address barriers to condom purchase by women, such as: - Home sales by women's organizations. - Sales through outlets frequented by women. - Include condoms with other feminine products.	Cost-effectiveness studies to determine the feasibility of this approach which may be country-specific.	Conduct this research and scale up where feasible.

BEHAVIOR CHANGE COMMUNICATION
TECHNICAL LESSONS LEARNED, UNMET NEEDS, AND RECOMMENDATIONS

TECHNICAL LESSONS LEARNED	UNMET NEEDS	RECOMMENDATIONS
1. Mass media can quickly raise awareness, change attitudes, and, in certain cases, encourage behavior change (i.e., increased condom use in Switzerland) in the general population. Mass media can also effectively influence societal values and norms, provide credibility to the severity of the problem, and support interpersonal interventions.	Continue to utilize mass media campaigns as an important component of HIV/AIDS prevention programs. Conduct research to improve the effectiveness of mass media to influence behavior change	Integrate mass media campaigns into the overall HIV/AIDS prevention program to improve the overall impact (see Lesson #2, below).
2. People usually want to learn more about AIDS from mass media than policy makers are willing to tell them.[10]	Influence policy makers to allow "bolder," more specific public health messages.	Encourage the use of workshops, audience approval studies, and survey results to reassure policy makers that most people want clear and specific information on AIDS.
3. Mass media is most effective when coordinated with interpersonal communication interventions		Continue the integration/coordination of mass media with person-to-person communication channels.
4. Person-to-person communication programs (1) require community involvement (both organized and informal communities) in planning and implementation, leading to community "ownership" (2) are most effective when implemented through "peer" educators	Identifying and utilizing "peers" more effectively. Use of incentives to improve program productivity and sustainability.	Continue to employ this approach in community based HIV/AIDS prevention programs. Conduct several operations research studies to improve the effectiveness of this approach and develop a "How to" manual to disseminate the approach. Review the experience from other projects in the Offices of Population, Health and Nutrition, and from the NGO/PVO work done by the Bureau for Humanitarian Relief.
5. Community level interventions (church or town meetings, community information campaigns, etc) can influence behavior changes (ie. increased condom use).		Continue/scale up this approach.

[10] "AIDS and Mass Persuasion", by Phyllis Piotrow, Rita Meyer, & Bernard Zulu, page 734. In: AIDS in the World, by Jonathan Mann, Daniel Tarantola, and Thomas Netter, Harvard University Press, Cambridge, Massachusetts, 1992.

BEHAVIORAL RESEARCH (1)

TECHNICAL LESSONS LEARNED, UNMET NEEDS, AND RECOMMENDATIONS

TECHNICAL LESSONS LEARNED	UNMET NEEDS	RECOMMENDATIONS
1. HIV/AIDS prevention programs have produced long-term behavior change among specific target groups: • Gay/bisexual men: small group and community level interventions can produce short-term behavior change, and brief skills training can maintain behavior change. • Injecting drug users: Community-based interventions can: (1) reduce risk through drug injection (i.e., needle exchange); and(2) to a lesser extent, through sexual transmission (i.e., condom use). • CSWs: There is extensive evidence that either: (1) HIV counseling/ testing; or (2) peer education/condom distribution can increase condom use. • STD clinic patients: Some evidence indicates that condom promotion (via videotape and/or small group discussion) will increase condom usage. Counseling/testing appears to promote safer-sex behavior among HIV-positive but not HIV-negative STD clinic patients. • Young adults (18-29 years): (1) Condom use decreases as the number of sex partners increases, (2) skills training for university students increased negotiation skills and positive attitudes toward condoms. • Adolescents: AIDS education appears to improve knowledge, attitudes, and behavioral intentions or behavior in the short term, intensive sex education delayed the onset of intercourse among students who had never had sex (but did not reduce "risk behaviors" among those already sexually active. • Adult heterosexuals: Several mass media campaigns (Switzerland) have increased knowledge, condom sales and use. In addition, couple/small group counseling and HIV counseling/testing also increase safe-sex behaviors.	More focused research and operations research with each of the target groups to identify the most cost-effective and efficient interventions to produce long-term behavior change.	• Gay/bisexual men: conduct research on ways to maintain behavior change. • Injecting drug users: operations research to improve effectiveness of current interventions. • CSWs: Studies to determine efficacy in reducing infections among CSWs and their clients and design more effective interventions to promote CSW condom use with "steady" partners. • STD clinic patients: More research on ways to reduce "risk behaviors" among HIV- negative and HIV-positive individuals. • Young adults: Research to identify interventions appropriate for nonstudent populations since "risk" increases as education and socioeconomic status decrease. • Adolescents: Operations research to improve effectiveness of current interventions, behavioral research to reduce "high risk" behavior among sexually active adolescents. • Adult heterosexuals: Operations research to improve effectiveness of current interventions.

TECHNICAL LESSONS LEARNED	UNMET NEEDS	RECOMMENDATIONS
2. The following "lessons learned" should be incorporated into HIV/AIDS prevention/control programs: • Sustained interventions are more likely to lead to sustained behavior change. • More intense interventions are more likely to result in greater risk reduction. • Accessibility to "devices" (needle exchange, condoms, etc.) reduces risk. • Skill building & the modification of community norms both appear to enhance behavior change. • Timing: intervening with adolescents before they become sexually active can have a greater impact. • Individual/ group counseling alone cannot reduce risk in entire communities because: (1) this is costly and (2) the highest risk individuals may not participate. • HIV counseling/ testing have an impact with some populations but is not sufficient for HIV risk reduction. • Working at the community level can lead to significant behavior change.	Continued research is needed in the following areas: • Conduct a more systematic evaluation of existing prevention interventions to measure effectiveness and efficacy. • Conduct research in how to maintain behavior changes over the longer-term. • Develop a standard for determining the efficacy of various prevention strategies (ie. a standard to determine whether a program will have public-health significance in terms of probable reductions in HIV incidence. • Study the negative side-effects (if any) of HIV preventive interventions. • Conduct additional studies on the following target groups: women, younger gay/bisexual men, young adults who are not in school, out of school adolescents, STD patients, and the military .	• Consider the "structural"/ contextual conditions for HIV risk behaviors. • Conduct basic studies of the dynamics of sexual behaviors and networks.
3. Results from behavioral research are not systematically used to improve HIV/AIDS prevention programs.	ATSP level management and coordination to ensure that research results are incorporated into the design of program interventions in a complete and timely fashion.	Incorporate such a ATSP management and coordination system into the design of ATSP III.

(1) Summary of results from: Choi, Kyung-Hee and Thomas J. Coates, "Prevention of HIV Infection," AIDS, 1994, August, pp. 1371-1389

POLICY
TECHNICAL LESSONS LEARNED, UNMET NEED, AND RECOMMENDATIONS

TECHNICAL LESSONS LEARNED	UNMET NEEDS	RECOMMENDATIONS
1. Policy makers can be educated to the serious impact of HIV/AIDS.	More wide-spread use of models which project the impact of the HIV/AIDS pandemic in terms which cause policy makers to take action.	Use a projection model which is: (1) simple to use (i.e., requires few variables and no specialized expertise to run); and (2) demonstrates socioeconomic impact rather than epidemiological impact. Develop and/or test a model which estimates the programmatic impact and relative cost effectiveness of various interventions (such as the Avert Model developed by AIDSCAP).
2. Experience shows five policy areas which are essential to support an effective HIV/AIDS prevention program: (1) Removing fees and regulatory obstacles from the promotion of condoms; (2) Making condoms available to youth (3) Making STD drugs available <u>without</u> prescription; (4) Eliminating fees and regulatory obstacles on the importation and marketing of STD drugs and condoms; and (5) Developing policies to protect HIV-positive individuals and their families.	Development of these policy requirements into a standard list of recommended policies to support national HIV/AIDS prevention programs (i.e., an international standard).	Promote development of this international Policy standard and its subsequent endorsement by WHO and the multi-lateral donors. Promote the adoption of these policy standards in each USAID-supported program.
3. Under certain circumstances, policy reform can significantly change community behavior (such as the Thailand 100% condom policy).	Identify the circumstances which made this policy reform successful.	Promote this policy reform where feasible.

4. Policy reform should be incorporated into each country action plan and implemented in coordination with other plan activities.	Close coordination between the NGO/ CBO capacity building CAs (such as The International HIV/AIDS Alliance, NCIH, and the AIDSCAP capacity building initiative, etc.) and the Policy Unit of the chief implementing agency (AIDSCAP).	Incorporate a management/ communication structure into the ATSP III design to enable this coordination and make the participating CAs accountable. The existing NGO network managed by NCIH could be mobilized to advocate for policy reform.
5. Workplace Policy and Prevention Programs can work under the following circumstances: (1) Demonstrate that prevention pays compared to the costs of worker attrition; (2) Provide case studies from other national industries; and (3) National leadership exists to promote the program.		Scale up this activity.
6. Policy level reform can influence contextual factors—societal values and community norms.	Research to identify the relationships between policy reform and contextual change.	Promising: conduct research (analysis of case studies) to measure the effectiveness of this intervention.

MONITORING AND EVALUATION (M&E)
TECHNICAL LESSONS LEARNED, UNMET NEEDS, AND RECOMMENDATIONS

TECHNICAL LESSONS LEARNED	UNMET NEEDS	RECOMMENDATIONS
1. It is critical that an M&E plan be designed into each national HIV/AIDS prevention strategy. Note: M&E approaches which identify cause and effect and/or relate overall change in the target population (impact) to specific interventions are expensive.	A standard set of guidelines to guide the development of the M&E component of each national plan. Presently, many of the stakeholders are not fully aware of the: • technical issues/data limitations • feasible timelines for completion • actual costs A consensus should be reached on M&E, as with all other parts of the national strategy, when it is approved for implementation.	Develop a standard set of guidelines which would incorporate the following: Specify indicators • Global Bureau/ATSP indicators: - Core (PIs) - Recommended list by intervention type • Mission level indicators: - Action-plan indicators Specify data collection methodologies Specify timelines and budgets
2. The design of M&E activities should be funded with core ATSP funds to assure continued support throughout implementation and final program evaluation.	In many cases, missions reprogram and/or do not provide sufficient funds to complete ongoing M&E activities.	Global Bureau and missions agreed on their respective M&E responsibilities as part of the overall country plan for ATSP interventions.
3. The ATSP (AIDSCAP) has developed several simple, cost-effective M&E methodologies: Triangulation or the integration of qualitative, quantitative, and process data into the evaluation of specific interventions. The Behavioral Surveillance Survey (BSS) can monitor the effects of prevention programming at the regional level.	Complete field testing of these methodologies.	Assuming successful completion of field testing, scale up these methodologies to be used worldwide.

TECHNICAL LESSONS LEARNED	UNMET NEEDS	RECOMMENDATIONS
4. The combination of the BSS (reporting every 6 to 12 months), along with a simple sentinel surveillance system (reporting annually) at the same site could cost-effectively monitor both behavior change (outcome) and HIV/STD prevalence (impact).	Promising—conduct field tests.	Scale up if successful.
5. Proven interventions should be monitored to assure ongoing progress, but do not necessarily need to be evaluated.	Guidelines to differentiate between interventions which require evaluation and those who should be monitored.	Develop these guidelines for use on the next ATSP.
6. Simple (HIV/STD) sentinel surveillance systems are critical to planning and managing ongoing country level prevention programs.	Standards for a simple sentinel surveillance system.	Organize an international working group to develop (and subsequently endorse) these standards for use on the next ATSP.

(NGO/PVO) CAPACITY BUILDING
TECHNICAL LESSONS LEARNED, UNMET NEEDS, AND RECOMMENDATIONS

TECHNICAL LESSONS LEARNED	UNMET NEEDS	RECOMMENDATIONS
1. A tremendous amount of ad hoc capacity building has taken place, primarily in the development of technical skills.		Develop a <u>systematic</u> approach in which training/capacity building is formally incorporated into each activity.
2. Capacity building, other than ad hoc technical skills transfer, will require additional resources and, more importantly, specialized expertise.	A policy which defines the importance (priority) of capacity building in the Phase III ATSP, in order to determine the level of resources and technical support to allocate to this activity. The following should be considered in the policy design: • The relative importance of results verses capacity building • A realistic timetable to achieve outcomes and impacts • The ability to scale up beyond the targeted organization	Organize a workgroup, including outside experts, to develop a policy on capacity building and incorporate guidelines into the Phase III design. Two alternatives are: • <u>Continue</u> to provide capacity building in technical areas as a component of ongoing programmatic support. • <u>Expand</u> scope of capacity building to include formal assistance in organizational development to support: - Organizational assessment - Organizational management skills - Systems development (accounting, personnel, etc.) - Networking/Global learning
3. To be most effective, a capacity building strategy must be built into the national HIV/AIDS prevention program from the start (i.e., which organizations will receive what level of support over what timeframe to achieve which outcomes).		Require the incorporation of a capacity building component into the design of each national HIV/AIDS prevention strategy.

TECHNICAL LESSONS LEARNED	UNMET NEEDS	RECOMMENDATIONS
4. The availability of a small grant mechanism to support CBOs is important to maintain program flexibility, respond to community requests, and, in some cases, field test a community based pilot. This approach, however, is management intensive. Financial support must be carefully managed since it can create dependency and discourage community initiative.	An effective mechanism to distribute resources to the community level, on a large scale, and monitor and evaluate these programs.	Continue this small grant funding mechanism in the redesigned flagship project(s) of Phase III. Evaluate the effectiveness of (and if effective, scale up) The International HIV/AIDS Alliance in supporting capacity building at the community level (i.e., financial and technical support of CBOs). UNICEF, and others, with experience in "social mobilization" should be consulted during this evaluation. Develop a series of "How-to" manuals to assist CBOs to design, implement, and evaluate community-level HIV/AIDS prevention activities. This series should consider the following: • Peace Corps has developed and field-tested a manual on how to community-based organizations can monitor and evaluate their programs. • UNICEF has developed manuals on how community based organizations can design a health communication strategy and plan interventions.

TECHNICAL LESSONS LEARNED	UNMET NEEDS	RECOMMENDATIONS
5. The NGO cluster approach to capacity building is effective (i.e., training/application of learned skills/ feedback and follow up). Example: • Train in proposal development/ project design • Use skills to develop initial proposal • Receive feedback during proposal review		Scale up this approach. This design of initial training, immediate use of learned skills, and rapid feedback should be used in most areas of training and capacity building.

WOMEN'S STATUS/EMPOWERMENT
TECHNICAL LESSONS LEARNED, UNMET NEEDS, AND RECOMMENDATIONS

TECHNICAL LESSONS LEARNED	UNMET NEEDS	RECOMMENDATIONS
1. Males and females should always be considered as separate target groups in the design and implementation of <u>all</u> research and programmatic interventions.	Research to identify how gender differences affect vulnerability to HIV infection and influence preventive behaviors. The incorporation of gender sensitivity into the design of national HIV/AIDS control strategies and their implementation at the programmatic level.	Conduct gender-specific research in the following areas: • social roles • patterns of communication/social support norms & values This research should target mainstream women—adolescents, young adults, and adult women in "stable" relationships. Incorporate the analysis of gender sensitivity as a <u>standard</u> component in the design of national HIV/AIDS control strategies and their implementation on the programmatic level. Develop several core indicators to measure gender-specific program outcomes and impacts (see Evaluation Project Guidelines).
2. Contextual and individual interventions are required to reduce women's vulnerability to HIV infection.	Research to identify effective interventions at the societal, community, and group levels to reduce women's vulnerability.	Identify the contextual (economic, cultural, social norms, etc.) issues which increase women's vulnerability and design/test interventions to reduce this risk.
3. Incorporate gender empowerment/peer support components into <u>all</u>, relevant interventions—this is extremely important to women and girls.		Make this a <u>standard</u> design requirement for all interventions.

TECHNICAL LESSONS LEARNED	UNMET NEEDS	RECOMMENDATIONS
4. Behavior research on females (ICRW) has shown: • Sexual initiation for girls can occur before menarche • Economic gain and sexual coercion underlie many young women's sexual experience. • The social expectation of virginity does not necessarily protect young women from STDs/HIV. • Social/ sexual inequalities increase adolescent and adult women's vulnerability. • Gender differences in socialization contribute to STD/HIV vulnerability • Social costs of HIV prevention may be too high to motivate behavior change.	Operations research to test the effectiveness of interventions (including established interventions) to reduce female vulnerability. Combine both qualitative and quantitative research methodologies. These interventions should include: • peer counseling and education • provide communication/support from trusted adults • involve adolescents in program design	Review the effectiveness of <u>all</u> current interventions, in terms of the ICRW research results, and <u>incorporate these findings</u> into the design and testing of future interventions through operations research. Broaden HIV/AIDS education to include a discussion of sexuality, relationships, and gender roles. Equip adults to be trusted sources of information and guidance. Make reproductive health services user-friendly. Mobilize communities against sexual violence. Increase adolescent and adult women's access to education and economic resources
5. Established women's groups can be mobilized to encourage women to adopt HIV/AIDS prevention behaviors.	Leveraging existing women's networks, both formal and informal, to advocate for contextual changes which empower women and support their visible and active participation in HIV/AIDS prevention programs.	Incorporate a plan to utilize existing women's networks into each national HIV/AIDS control strategy and into each intervention at the programmatic level. Develop several intermediate "core" indicators to measure this process, targeting high transmitter groups is most effective in high risk/urban populations, where short distances and laboratory infrastructure usually make this approach feasible.

4. Recommendations

A. Introduction

USAID, through the AIDS Technical Support Project–Phase II, has remained a world leader in combating the spread of the HIV/AIDS epidemic. ATSP–Phase II has educated millions of people in HIV/AIDS prevention and control, raised the awareness of national policy makers, facilitated positive policy reforms, established innovative bilateral and multilateral partnerships, and developed an effective, three-pronged intervention strategy to slow the spread of the disease. This extensive review of the available ATSP–Phase II results, obtained through document reviews and expert interviews, indicates that USAID should incorporate the following proven and promising technical approaches into the third phase of this critically important program.

This chapter is divided into three major sections:

- Overall Recommendations

  This section presents the general strategies USAID should consider in the design of the ATSP–Phase III. These strategies will leverage USAID's comparative advantages in two areas: 1) the design and demonstration of improved, field-based approaches to HIV/AIDS prevention and control; and 2) the subsequent promotion of these approaches through various modes of dissemination at both the programmatic and policy levels.

- Intervention-specific Recommendations

  This section identifies the proven and promising approaches that USAID should consider during the design of the major components of the ATSP–Phase III.

- Future Programming Areas for Consideration

  This section discusses two areas in which USAID has invested limited resources to date but might be considered for inclusion in the ATSP–Phase III design.

B. Overall Recommendations

1. Strategies

USAID should consider the following strategies during the upcoming redesign of the ATSP:

- Policy reform at the international donor and country levels—several interventions have been sufficiently field tested and proven effective—it is now time to scale them up. In several areas, USAID could leverage its influence with other international donors to develop international standards and encourage their adoption by national governments. Currently, the most critical areas are:
  - Syndromic Management of STDs
  - Prescribing regulations to allow wider access to drugs
  - Mechanisms to ensure an adequate supply of STD drugs
  - Mechanisms to ensure an adequate supply of condoms
  - A simple, low-cost, rational Surveillance System standard and Worldwide Reporting System which provides sufficient data to interpret trends in STD/HIV prevalence and allow interpretation to determine limited incidence.

- Technical assistance at the programmatic level to assist clients at all levels to design and implement improved programs. USAID should leverage this TA by producing—possibly in collaboration with UNAIDS—a series of "How-to" manuals, guidelines, and case studies demonstrating the most effective design, implementation, and monitoring and evaluation of these proven interventions. Many of these documents already exist or could be easily developed based upon present knowledge. Some will require external TA to properly implement, such as the Targeted Intervention Research (TIR) methodology to improve STD health-seeking behavior, while others have been designed to be used by community leaders, such as the manual on the design, monitoring, and evaluation of community programs produced by Peace Corps.

- Research focusing on immediate programmatic needs (short-term) and on "scanning" the field, possibly in collaboration with others, to identify promising work which supports ATSP–Phase III goals.

2. Priority Groups

Many prevention efforts to date have effectively focused on high-risk groups and efforts should be continued to reduce HIV transmission through these groups. In the future, however, more effective prevention and control of HIV will also depend upon the expansion of interventions to other groups who are increasingly vulnerable to the virus.

The ATSP–Phase III should focus on the following three priority groups:

- High risk men and women
- Low-risk women
- Youth (ages 15-29).[11]

3. Cross-cutting Issues

USAID should consider incorporating the results from two new, promising approaches into the design and implementation of all appropriate interventions in the next ATSP in order to enhance their effectiveness.

- Gender Sensitivity: Research under the ATSP–Phase II has demonstrated that gender differences affect vulnerability to HIV infection and influence the effectiveness of preventive behaviors. These research findings to date should be incorporated into the design of STD/CSM/BCC interventions under Phase III. In addition, the next phase of the ATSP should support more research on this topic and design a formal mechanism to incorporate these research results at the programmatic level in a timely manner.

- Contextual Change: Research under the ATSP–Phase II has also demonstrated that social structures, social norms, and community values influence individual vulnerability and behavior. Although some changes in social and groups norms may be longer-term, the new ATSP should incorporate into interventions for Phase III what is presently known from the ATSP–Phase II, as well as from USAID experience in family planning and child survival.

C. Intervention-Specific Recommendations

The three major ATSP-supported prevention interventions—STD reduction, condom social marketing, and behavior change communication (BCC)—have proven effective in preventing and controlling the transmission of HIV and should remain the focus of the next phase of the ATSP. Two of these, condom social marketing and the syndromic approach to STD diagnosis and treatment, have proven to be successful interventions and should be scaled up. While some BCC interventions have also proven effective and should be scaled up, this component would benefit from additional research.

[11] Some research recommends that, to be most effective, AIDS education/prevention programs should begin at ages 9-10.

Program-level recommendations for each of the three major interventions and their supporting areas follow.

1. Prevention Intervention One: STD Reduction

The second phase of the ATSP has done an excellent job in demonstrating the effectiveness of the STD syndromic management approach at the service delivery level, and has facilitated the integration of this approach into the National STD Guidelines of several countries. The program has also developed and field tested the TIR Methodology which has enabled local program managers and community leaders to conduct research to improve the quality and "attractiveness" of STD services to potential clients, both proven strategies for increasing client demand.

For the ATSP–Phase III, USAID should consider the expansion (scale up) of these interventions in the following ways:

- At the highest policy levels, the ATSP–Phase III should coordinate with UNAIDS to:

  - Promote STD syndromic management (a cost-effective intervention recommended by the WHO) as an international standard to be incorporated into the National STD Guidelines of most HIV/AIDS affected countries;

  - Promote international donor coordination to assure the provision of a sufficient supply of STD drugs to support country STD syndromic management programs as they are developed and expanded;

  - Facilitate, through an international donor effort, the development of a simple, low-cost international standard for a STD/HIV Sentinel Surveillance System; and

  - Lobby to remove barriers (e.g., prescribing regulations) that limit access to STD prevention programs and treatment services to the principal target groups (high-risk men and women, low-risk women, and youth).

- At the program level, the ATSP–Phase III should focus the provision of TA to support the expansion (scaling up) of STD services with an emphasis in the following areas :

  - The design and implementation of interventions to establish the syndromic management approach;

  - Widespread dissemination of the TIR methodology to promote increased demand for services among infected populations; and

- The development of social marketing programs to promote STD treatment kits (where appropriate).

- In the areas of research and future program development, the ATSP–Phase III should focus on the development of products and services to reduce risk and expand access to low-risk women (youth and women in stable relationships) who are increasingly becoming infected. To protect these women from STD/HIV infection, the new ATSP should promote:

  - STD/HIV/FP service integration: This is a very promising area based upon the ongoing IPPF/ WHR pilots in Brazil, Honduras, and Jamaica. This integration would allow a significant expansion of STD/HIV treatment services through an already established clinic network. Preliminary results from the IPPF/WHR evaluation are positive, so that a scale up of this approach should be designed into the next ATSP;

  - Continue to support improvements in STD syndromic management and the development of improved STI diagnostics and risk profiles for asymptomatic women; and

  - Continue the development, field testing, and eventual distribution of female barrier methods:

    -- Complete the acceptability/affordability trials of the female condom and, if feasible, begin widespread distribution through social marketing programs; and
    -- Conduct an external expert evaluation of the USAID-funded program to develop a **non-contracepting** microbicide and develop a strategy on continued funding (based upon progress, other donor support, etc.).

2. Prevention Intervention Two: Condom Social Marketing

Under the second phase of the ATSP, condom social marketing has dramatically increased condom availability, with distribution at over 215 million condoms. The further expansion of social marketing programs worldwide, however, is currently limited by the lack of sufficient condom supply.

- At the policy level, the ATSP–Phase III should:

  - Organize an international donor working group to coordinate efforts to increase the supply of condoms by: 1) donor purchase; 2) country purchase; and/or 3) the elimination of legislative/ regulatory constraints on condom importation, marketing, and purchase.

As donor funding for HIV/AIDS prevention programs decrease, program efficiency and sustainability will become increasingly important. Since condom social marketing is a proven intervention, the ATSP–Phase III should consider the following at the programmatic level:

- Continue to develop/expand (scale up) social marketing programs;
- Encourage the increasing sustainability of established programs through capacity building and operations research to increase efficiencies; and
- Examine the feasibility of continued distribution of free condoms to reach some target groups.

3. Prevention Intervention Three: Behavior Change Communication/Behavior Research

This is the most challenging of the three major interventions. BCC will require an investment in additional research and new applications of lessons learned from USAID's experience in related population and health/child survival programs. The ATSP cooperating agencies and others have demonstrated that BCC interventions which incorporate the following characteristics can change short-term and/or longer-term behavior:

- ✓ Specify a target group
- ✓ Focus on specific behavior(s)
- ✓ Use multi-channel, reinforcing message(s)
- ✓ Use peer-to-peer education/reinforcement
- ✓ Build intervention on NGO/PVO strengths.

Based upon these BCC results, the ATSP–Phase III should:

- Incorporate this proven approach into a "How-to" manual for widespread dissemination and focus on building the capacity of local individuals and institutions to use this approach more widely; and
- Incorporate more mass media to support STD/CSM/BCC interventions and influence community values and norms.

Future research in the area of BCC should:

- Focus on additional research to improve the effectiveness of BCC interventions with specific target groups, especially the critical target group: youth and adolescents; and
- Examine how BCC can more effectively influence societal norms and community values.
- How to improve perception of personal risk.

4. Supporting Interventions

To enhance the impact in the three major intervention areas, the ATSP–Phase II supported work in: 1) policy development; 2) monitoring and evaluation; and 3) PVO/NGO support (capacity building). Each of these supporting areas will continue to be important to increasing the effectiveness and impact of the three major interventions. To achieve this synergy, USAID should consider redesigning these supporting interventions and improving their coordination.

These supporting activities should be incorporated into each Country Action Plan from the start, a task not always accomplished under ATSP–Phase II. The plan should specify how and when policy initiatives will be utilized to support major condom, STD, BCC interventions, how and when these major interventions will be monitored and evaluated, and which local institutions will receive assistance in building capacity, etc. Such integration/coordination should increase program effectiveness.

In addition, the ATSP–Phase III should incorporate sufficient staff expertise, accountability, and resources at the appropriate program levels to ensure that these supporting activities are properly designed and carried out. For example, the AIDSCAP regional offices had no staff with policy expertise nor, apparently, the responsibility to manage/coordinate policy activities at the regional or country level.

a. Policy Reform

If policy reform and advocacy are to be a priority in ATSP–Phase III, this capability should be expanded to promote policy reform in support of the major interventions—STD/CSM/BCC—and programs in areas of new emphasis, such as women's empowerment and contextual (norms/values) change.

This expanded policy unit, under the ATSP–Phase III would:

- Organize/facilitate policy reform in the three major intervention areas—STD/CSM/BCC—at the international and country levels;
- Scale up the AIDS Private Sector Presentation/Work Place Presentation which has proven effective in involving the private sector in HIV/AIDS prevention programs;
- Monitor/coordinate the implementation of policy reform at the country level, with the NGO/CBO networks which have been (are being) established by both NCIH and the International HIV/AIDS Alliance;
- Promote more widely simple-to-use models which demonstrate the socioeconomic consequences of the HIV/AIDS epidemic to raise awareness among policy makers and encourage them to act (including testing/application of the AIDSCAP/Avert model as well as building upon the existing experience from the Office of Population's RAPID and Population Policy Projects).

b. Monitoring and Evaluation (M&E)

M&E, under ATSP–Phase III should emphasize the following:

- Sufficient funds should be committed by either the Global Bureau and/or the Mission to support M&E activities and to ensure that these activities are completed on schedule;

- It is critical that the M&E plan be incorporated into the original implementation plan and reviewed/approved by all stakeholders (i.e., Global Bureau, Mission, ATSP/CA, country-level stakeholders, etc.) to reach agreement on the objectives, costs, and schedule for competition of the M&E component;

- Not all interventions need to be evaluated. Consensus should be reached, probably during the design of each intervention, as to whether the approach has been proven and therefore only requires monitoring (to track progress), or whether the approach is innovative and should be formally evaluated; and

- Promote (scale up) the adoption of the BSS methodology, a simple, cost-effective approach to monitor and evaluate program outcomes on the local and regional levels.

Two principal areas for future research are:

- Development of a low-cost, rational Surveillance System Standard to enable countries to monitor STD/HIV trends; and

- Further development/refinement of both standard (core) outcome indicators and actual or surrogate impact-level indicators.

c. PVO/NGO Support ("Capacity Building")

Capacity building of local PVOs/NGOs is important for long-term program expansion and sustainability and has been demonstrated to be effective in the areas of family planning, MCH, and child survival. In preparation for the ATSP–Phase III design, USAID should review the experience of previous population and health projects in this area.

The ATSP–Phase III design should consider the following:

- Determine the level of resources that should be invested in capacity building during the ATSP–Phase III design. (See Section 3. Matrices, which outline the relative investment in providing capacity building in specific areas, compared to conducting an complete organizational assessment and developing an overall organizational development plan);

- Design a small grants program into the new project to be managed at the country level, allow a flexible response to community requests, and test the feasibility of community-level pilot projects; and

- Evaluate/expand the Alliance approach to PVO/NGO capacity building and organizational support.

D. Future Programming Areas for Consideration

The HIV/AIDS epidemic has established itself worldwide and future strategies should consider the needs for: 1) linking prevention with care; and 2) building community capacity to respond on the local level. The UNAIDS Strategic Plan illustrates the importance of these areas:

> *The fact that the epidemic and its consequences will be with us for generations implies the need for a sustainable response, linking prevention with care and support, and building up the capacity of individuals and communities to cope with HIV and AIDS* (UNAIDS Strategic Plan 1996-2000, page 5)

1. Linking Prevention with Care

As an HIV/AIDS epidemic grows and eventually stabilizes within a given population, the most effective program response also shifts from an initial emphasis of prevention toward a response that integrates both prevention and care (See Chapter 1., Figure 1: "The HIV Prevention to Care Continuum," page 8). In several countries where seroprevalence is high, the present ATSP is supporting several small, community-based demonstrations of social-psychological care and support to HIV positive groups and those living with AIDS. Such programs have already proven successful in supporting HIV positive individuals and their families in high prevalence countries, such as TASO in Uganda. USAID should consider these models as examples of clearly-defined, limited approaches to integrate nonclinical care strategies with prevention in the appropriate settings. Some examples are:

- A manual on guidelines and "best practices" for home/community care for those who are HIV positive or have AIDS;

- Guidance on the social-psychological and legal support for HIV-positive individuals and their families;

- Guidance on maintaining economic productivity among HIV-positive individuals.

- Developing innovative approaches to support women with AIDS or as caregivers for people with AIDS.

- Guidance on utilizing community partners—churches, social groups, traditional healers, etc.

2. Development/Expansion of CBO/Social Mobilization Programs

USAID should consider the incorporation of mechanisms to support the development and expansion of CBOs into the design of the ATSP–Phase III. Any development in this area, however, must be carefully researched and designed using the experience from other USAID sectors and other donors.

UNICEF, for example, has found that:

- Mechanisms to transfer funds must be carefully designed and managed to avoid local corruption and dependency on international sources;

- Umbrella organizations can be effective local managers of funds and technical assistance requests but can also develop into powerful gatekeepers with a monopoly on these important resources; and

- The availability of international funds can also discourage local initiative and program sustainability.

In addition to building upon previous experience to design an effective CBO support mechanism, the ATSP–Phase III might also support research on what types of responses communities have already organized without external TA and financial support. The most effective mechanism may not be to provide financial assistance to local community groups. Instead, it may be more effective to develop NGO/CBO networks which would disseminate the results from successful community programs and formally link community leaders to encourage the expansion and replication of successful models and to advocate for expanded government support.

ANNEX A

List of Documents

LIST OF DOCUMENTS

1. USAID Responds to HIV/AIDS, A Report on the Fiscal Year 1994 HIV/AIDS Prevention Programs of the USAID, 1995.

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ANNEX B

List of Individuals Contacted

List of Individuals Contacted

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