

JULY 1996

AIDS

FAMILY HEALTH INTERNATIONAL
VOLUME III, NUMBER 2

PN-ABY-853



New Insights in
HIV/AIDS Prevention

Study Confirms Oral Sex Risk

Results from a series of studies of simian immunodeficiency virus (SIV) in monkeys have provided the first laboratory-based evidence that receptive oral sex puts people at risk of acquiring HIV/AIDS. The findings, which were published in the June 7 issue of *Science*, suggest that HIV can infect individuals through the mouth even when they do not have open sores, cuts or gum disease.

Six of seven monkeys tested contracted SIV when it was applied to the backs of their mouths, researchers from the Dana-Farber Cancer Institute, Tufts University and the Tulane Regional Primate Center reported. SIV differs slightly from HIV, but researchers believe that these results indicate a significant health threat to people.

There is no evidence that casual contact or even mouth-to-mouth contact such as kissing or sharing utensils can spread HIV. The amount of HIV in saliva is much lower than the concentrations of SIV applied in the monkey studies.

Given little epidemiological evidence of HIV transmission through oral sex—in part because it is difficult to find people who have engaged in oral sex but not other forms of high-risk sexual contact—some have mistakenly assumed that oral sex is “safe sex.” The U.S. Centers for Disease Control and Prevention, however, has for many years recommended condom use during oral sex.

WHO Warns of Infectious Disease Threat

HIV/AIDS and other infectious diseases are responsible for one-third of all deaths worldwide, the World Health Organization (WHO) reported. In 1995 more than 17 million people, including 9 million young children, died from bacterial, viral and parasitic diseases.

WHO’s World Health Report warns that cholera, malaria and tuberculosis are making deadly comebacks, while new infections such as HIV and Ebola virus are emerging. At least 30 new infections have been recognized during the past 20 years.

Controlling infectious diseases is becoming more difficult and expensive because bacteria and other microbes are developing resistance to antibiotics and other life-saving drugs. For example, some of the best and most affordable antibiotics against the two bacteria that cause most cases of pneumonia are no longer effective.

The report makes recommendations for controlling or eliminating diseases for which cost-effective interventions already exist and for expanding surveillance and research to respond to the threat of emerging diseases. While many of these diseases could be prevented or cured for as little as one dollar per person, most countries have not invested adequately in their control.

HIV Cofactor Identified

Scientists have discovered the second of two molecules that make it possible for HIV to enter immune system cells. Researchers at the National Institute of Allergy and Infectious Diseases (NIAID), who reported their findings in the May 10 issue of *Science*, named this cell molecule “fusin” because it allows certain strains of HIV to fuse with and enter cells.

In the mid-1980s, a molecule on the surface of immune system cells called CD4 (cluster designation 4) was identified as the primary receptor for HIV. The NIAID scientists found that fusin is also necessary for the entry of HIV-1 into cells.

The findings present new insights into how HIV enters the cells as well as a better understanding of the pathogenesis of the virus. This knowledge will enable researchers to create an animal model to study HIV-1 infection and to test drugs and vaccines against HIV. Further study of fusin may also explain why individuals who have been exposed repeatedly to HIV have not become infected and why others who are HIV-positive have had little or no decline in the functioning of their immune systems.

AIDS*Captions* is published
 Three times a year by
 Family Health International's
 AIDS Control and Prevention (AIDSCAP)
 Project

AIDS*Captions*
 Family Health International
 2101 Wilson Blvd., Suite 700
 Arlington, Virginia 22201 USA

Telephone: 703 • 516 • 9779
 Fax: 703 • 516 • 9781

**Associate Director
 for Information Programs**
 Mary O'Grady

Senior Editor
 Kathleen Henry

Editor/Writer
 Margaret J. Dadian

Graphic Designer
 Sandy Paul

Publication Assistants
 Michael Buja
 Diana Randall

Family Health International (FHI) is a
 nonprofit research and technical assistance
 organization dedicated to contraceptive
 development, family planning, reproductive health
 and HIV/AIDS prevention around the world.

FHI implements the AIDSCAP Project in
 collaboration with:

The Center for AIDS Prevention Studies,
 University of California,
 San Francisco

John Snow, Inc.

Ogilvy Adams & Rinehart

Population Services International

The Program for
 Appropriate Technology in Health

Prospect Associates

The Institute for Tropical Medicine, Antwerp

The University of North Carolina at Chapel Hill

The University of Washington at Seattle



AIDS*Captions* is supported by the U.S. Agency
 for International Development (USAID) under
 the AIDSCAP Project. The contents do not
 necessarily reflect USAID or FHI policy.



Volume III, Number 2

July 1996

AIDS Prevention for Refugees:
 The Case of Rwandans in Tanzania 4

The India-Nepal Partnership:
 Building Cross-Border Collaboration in Areas of Affinity 10

Counseling and Testing for HIV/AIDS Prevention 14

Communication to Change Behavior:
 A Coordinated Approach to HIV/AIDS Prevention 17

Casting a Wider Net:
 Improving Access to Condoms 21

Public Health Approaches to STD Control:
 New Challenges in the Era of AIDS 24

Evaluating HIV/AIDS Prevention Programs:
 Meeting the Challenge 29

Partnerships for HIV/AIDS Prevention:
 Promoting Collaboration in Ethiopia and Tanzania 35

Departments

In the News **facing page**

Opinion 39
*Expanding the Partnership: The Private Sector's
 Role in HIV/AIDS Prevention*

Q&A 42
*Field Testing a Rapid Project Development Method:
 Tanzania and Honduras: Case Studies*

Women's Forum 46
*Female Condom Study Explores Role of
 Peer Support in Sustaining Use*

Policy Profile 49
Influencing HIV/AIDS Policy in Kenya: NGOs Build Consensus

Resources 52

Cover Photo:
 Rwandan refugees go for water at the Benaco camp in Tanzania, site of the
 first large-scale, early HIV/AIDS prevention project in a refugee setting.
 Gilles Peress/Magnum Photos
 This issue was designed by Richard Fletcher.

AIDS Prevention for Refugees

The Case of Rwandans in Tanzania

by Judy A. Benjamin

Since genocidal civil war broke out in Rwanda in 1994, a unique HIV/AIDS prevention and care program—the first large-scale early interventions in a refugee camp—is helping to protect hundreds of thousands of refugees from infection.

Outside a clinic tent in the Benaco refugee camp in Tanzania sits an emaciated woman, holding a small child. So weak that she can barely rise when the counselor calls her name, she looks far older than her 25 years. Neither cholera nor malaria—afflictions that plague many in the camp—is the reason for her suffering; she is one of many refugees from Rwanda with AIDS.

The epidemic has hit Rwandans hard. For some sectors of the population, infection rates have been among the highest in Africa. In 1992, for example, testing of pregnant women attending antenatal clinics in the Rwandan capital, Kigali, revealed that more than 30 percent were seropositive. When genocidal civil war broke out in the spring of 1994, hundreds of thousands of Rwandans fled, and HIV inevitably followed them into hastily constructed refugee camps in neighboring Tanzania and Zaire.

Only four months after the exodus began, the AIDS Control and Prevention (AIDSCAP) Project con-



A project counselor talks to a young woman with AIDS.

tracted with CARE International to manage a broad-based HIV prevention pilot project for Rwandan refugees at Benaco, one of the first ever to attempt early large-scale interventions within a refugee camp. Because so little research on AIDS prevention has been done within refugee settings, the pioneering work at Benaco and three other Ngara District camps offers valuable lessons on working with displaced populations under crisis conditions.

Season of Slaughter

In April 1994, the longstanding political and ethnic conflict between Hutus and Tutsis reached the breaking point when a plane carrying the presidents of Rwanda and Burundi was shot down. A few hours later, the widespread slaughter of Tutsis by the Hutu majority began, and the world watched news broadcasts of the atrocities in disbelief. When Tutsi forces gained control of the country several weeks later, nearly half a million Hutus fled across the border into Tanzania, and even more sought refuge in Zaire.

Within a matter of days, the refugee population in the Benaco camp, only 18 kilometers from the Rwandan border, swelled to more than a quarter million, making it the second largest city in Tanzania. The United Nations, CARE and other NGOs responded swiftly to provide emergency relief to the refugees, setting up a food distribution network, warehouses, sanitation and health facilities, and other services. A second camp, Musahara Hills, opened nearby to relieve some of Benaco's overcrowding.



Refugee women face a life of grueling toil and increased vulnerability to violence and sexual assault

But other concerns soon surfaced. The conditions of refugee life greatly increase the risk of exposure to HIV and other sexually transmitted diseases (STDs). The destruction of families, deterioration of social structures and unraveling of social mores, loss of homes and income, overburdened health care resources, and crowding and commercial sex trade within refugee camps are just some of the factors that lead to increased risk-taking behavior and susceptibility. Women and adolescent refugees, vulnerable to violence, rape and coercive sex, are at especially high risk.

Before the war, CARE and AIDS-CAP had begun a community-based AIDS prevention project in northern Rwanda, but activities halted when the conflict accelerated. Given the high rate of HIV in Rwanda, there was fear that the number of HIV infections might rise precipitously among the refugees. USAID and AIDSCAP responded by shifting funds from the Rwanda program to the camps, and the AIDS/STD Prevention Project for Rwandan Refugees began in August.

Designing Appropriate Strategies

The project uses community outreach education and condom distribution to encourage refugees to change behaviors that put them at risk of sexually transmitted HIV and other STDs. The target population is all sexually active persons, with special efforts directed toward women without partners, young men and adolescents. As the lead implementing agency, CARE is responsible for the overall management of the program, with Population Services International (PSI)

handling condom distribution and promotion, and John Snow Inc. (JSI) providing assessment and evaluation support.

Findings from a baseline knowledge, attitudes, beliefs and practices (KABP) survey conducted by JSI, with the assistance of CARE and PSI, revealed the gravity of the problem. Reported condom use was low—16 percent for men during the most recent sexual encounter—despite the fact that 87 percent of respondents knew at least two ways to prevent HIV infection, one of which was condom use. This high level of awareness is due largely to the prevention messages these refugees received from aggressive anti-AIDS campaigns at home in Rwanda. More than half of the respondents perceived themselves to be at moderate or high risk for HIV infection.

Given the possible resistance to condoms revealed by the KABP and in early interactions with the refugees, project managers felt that an exclusive focus on condom use was not wise. Other behavior change strategies, such as promotion of fewer sexual partners and loyalty to

When genocidal civil war
broke out, HIV followed
Rwanda's refugees into
hastily constructed refugee
camps in neighboring
Tanzania and Zaire.



Traditional dancers incorporate HIV prevention messages into their performances during half-time at soccer matches.

one partner, and aggressive treatment and follow-up of STDs also became centrally important. The project collaborates closely with the African Medical Research and Education Foundation (AMREF) to promote STD treatment through syndromic management. AMREF trains medical assistants, supplies drugs and sponsors a mass education campaign in the camps and the adjacent Tanzanian village, Kasulu. CARE has trained 14 counselors to give health education sessions on AIDS and STDs to patients awaiting treatment at outpatient clinics.

The intervention also depends upon a network of approximately 100 AIDS community educators (ACEs) recruited from the refugee population. ACEs deliver AIDS/STD prevention messages in one-on-one encounters and group sessions to members of their own communities and make referrals for STD treatment in the privacy of refugees' dwellings. Condoms are dispensed free of charge by ACEs and by special condom promotion teams and peer educators; within the first 12 months of the project, more than 1.5 million were distributed.

A home-based care component

was added after the first year as more and more HIV-infected camp dwellers developed AIDS. Volunteers trained in home care regularly visit homebound refugees, bringing water, firewood and food. To avoid further stigmatization of people with AIDS—a serious problem among Rwandan refugees—the project does not single out AIDS patients; any ill or disabled person without family support can receive home-based care services.

A high level of collaboration between agencies is needed to carry out the home-based care program. NGOs work together to coordinate the distribution of clothes, blankets, cooking utensils and other items,



The conditions of
refugee life greatly increase
the risk of exposure to HIV
and other sexually
transmitted diseases.



and have helped a group of refugee women start a kitchen to prepare food for those unable to cook for themselves.

Women and Girls at Risk

I know a rapist who lives very close to us. A boy of 20 years took a lot of alcohol and got drunk. Then he attacked a six-year-old girl. He saw her going to the latrine and followed her in—we knew it because we heard her shouting. They took the boy to the security agents, but he ran away. They took the child to the clinic quickly, and it became necessary to refer her to the hospital. She stayed there quite a few days.

(excerpted from remarks by a participant in an unmarried mothers' focus group discussion)

The harshness of refugee life for women goes far beyond the double work day and backbreaking toil so familiar to African women. Many Rwandan women on both sides of the conflict were beaten, raped and tortured. Tragically, the violence did not end when the women finally arrived at what should have been their refuge—the refugee camp.

One of the biggest threats to the physical safety of women and girl refugees is the lack of employment for men, which leads to boredom, depression and an increase in alcohol consumption—which in turn lead to increased domestic violence and rape. Unfortunately, few rapes are ever reported to the authorities, partly for fear of retribution, partly because Tanzanian law makes prosecution for rape nearly impossible.

Women without male protectors (husbands, fathers, uncles) are particularly vulnerable in the camps. Many women who were raped during the conflict have given birth to babies. These so-called “unmarried mothers” are easy targets, with no one to stand up for them. They report that men walk into their huts at will, rape them and leave. Because they occupy such a low rung on the



Fertility is highly valued in Rwandan culture, and refugees seek to replace children lost in war.

social ladder, they receive little sympathy from the community. The project helped start support groups for these women, who have found strength by uniting with others suffering the same fate. They also benefit from special income-generation efforts, such as produce-growing cooperatives, recently started by other NGOs within the camps.

When the camps were new, large communal latrines were built some distance from the dwellings. These structures, sheltered by large sheets of plastic, became the site of many sexual assaults on women and girls. The situation improved after small four-family latrines were built nearer homes, replacing most of the communal ones. Women and children seeking firewood outside camp boundaries have also been victims of assault. Most relief agencies in the

camps now agree on the need to involve women in the early stages of camp layout and fuel collection to improve security.

In the Ngara District camps, project staff, NGO health service providers, community and psychosocial service agencies, and other interested parties participate in regular discussions to seek solutions to violence against women. One outcome of these discussions was the formation of a crisis intervention team made up of refugee social workers, counselors and other volunteers who provide counseling, medical and legal assistance, and social support for victims of sexual assault.

Even women who are not victims of violence and sexual assault are often powerless to insist on safer sex practices. Because condom use is

often associated with promiscuity, women are afraid to suggest condoms to their partners. Economic survival for some refugee women may mean exchanging sex for money or goods—sometimes even for water. Such coping strategies put women at higher risk for HIV and other STDs than do the coping strategies of male refugees.

Reaching Young People

Cultural barriers pose a special challenge to creating prevention programming for younger refugees. In Rwanda, not even parents discuss sexual matters with adolescents, and community educators and health care providers in the camps feel greatly constrained by such taboos. ACEs have been reluctant to include adolescents in AIDS and STD education sessions, even though they

know that adolescents are their most important target group.

Conditions in the camps deepen the problem. There are no secondary schools, so most adolescents are idle, and parents have little control over their activities. Rural teenagers quickly adapt to the street-wise behavior demanded by camp life. Many adolescents, orphaned or separated from their families, live on their own.

Project staff soon learned that sports events are perhaps the most effective medium for reaching young people—especially young men—with HIV/AIDS prevention messages. PSI helped construct a community sports complex with a soccer field and volleyball, handball and basketball courts. Weekly sports events—for most refugees, the only available form of recreation—draw thousands. Special events, such as foot races, are also very popular. During intermissions, traditional dancers incorporate HIV/AIDS prevention messages into their performances. PSI and CARE staff distribute condoms and use megaphones to broadcast prevention messages and songs.

Adolescent girls, who are at the greatest risk of acquiring HIV and other STDs, are the most difficult to

HIV prevention programming
for refugees must address
the greatly magnified
vulnerability of women and
young people struggling
through social crisis.

reach. Unlike boys, who can earn a few shillings running a bicycle taxi service, gambling or selling firewood or water, girls have little opportunity to earn spending money in the camps and may be coerced into exchanging sex for money, gifts or protection. Young girls are sought by older men as sex partners because they are presumed to be free of HIV. During focus group discussions, young girls admitted having difficulty saying no to sex even with boys their own age. The project is developing income-generating activities for adolescent girls to provide them with productive activity and enable them to earn money without endangering themselves.

Encouraging refugee youth to seek health care—even for painful cases of STD—is another challenge. To demystify health clinics and improve access to services, the project organized a series of “Adolescent Health Days,” which featured tours of clinic facilities, basic health screening and prize drawings. The first event drew more than 700 people outside one clinic. Focus groups revealed the critical need for basic reproductive health and anatomy education. Sign-up sheets for family health education classes filled up quickly.

Culture and Behavior Change

HIV/AIDS prevention staff in refugee settings must understand the cultural and social context in which they are working. Complex power relationships shape social interactions, permeating every facet of camp life and affecting the outcome of project efforts.

By meeting with both political and religious leaders of the various communities within the camps, project staff were able to learn about broadly shared attitudes and anxieties about HIV/AIDS and how best to design culturally acceptable prevention initiatives. Formally introducing new ACEs to these leaders has proven to be an effective way of gaining acceptance by a refugee community with a high level of fear and distrust.

Project staff have tried many different approaches to encouraging individual action, which helps refugees, too often passive recipients of assistance, regain a sense of control and self-sufficiency. One of the more effective strategies popularizes condom use through self-empowerment, using the theme “The power to choose.” Another message—“Treat STDs to protect and ensure future fertility”—has prompted many refugees to seek treatment because of its appeal to the importance of childbearing in Rwandan culture.



Judy A. Benjamin

Community educators learn about proper condom use so they can teach other refugees.



A film crew videotapes an HIV/AIDS education session with schoolchildren that was later shown on World AIDS Day.

Involving community members in HIV/AIDS prevention activities also helps give them a sense of control and ownership. One of the most popular activities for both community volunteers and audiences are HIV/AIDS prevention skits that refugees write and videotape themselves.

Few of the refugees in the Ngara District camps have returned to Rwanda, so the project's prevention efforts have continued into a second year. Eighty-four percent of respondents to a second KABP conducted after the project's first year reported they had received AIDS/STD prevention messages in some form, and about 80,000 people were motivated to seek counseling.

Unfortunately, condom use had not increased in that year. There may be several different reasons for this, including rumors that condoms contain HIV, the strong drive to replace children lost in the war, and religious leaders' equation of condoms with promiscuity. Other findings are more encouraging—an overall decrease in the number of multiple sexual partners, improve-

ment in knowledge about HIV transmission modes, less social isolation for women—and suggest that the project is having a positive impact.

A Population with Special Needs

Working with refugees stretches the boundaries of traditional prevention programming. The project's ongoing experiences in the Ngara District offer numerous insights for future work with refugees, many of which can be summed up in three general lessons learned.

First, planning HIV prevention programming for refugees requires flexibility, creativity, cultural sensitivity—and a great deal of patience. Behavior change comes slowly in any environment, but in a refugee camp where people struggle with survival issues far more real to them than the mysterious AIDS virus, changing sexual behavior can seem to be a monumental task. Yet the project has shown that it is possible to successfully engage refugees at many levels to promote health-seeking behavior, largely through empowerment and enabling strategies.

Second, HIV prevention programming for refugees cannot be successful if it does not address the greatly magnified vulnerability of women and young people struggling through social crisis. Women—particularly those without men—need assistance in developing both self-esteem and income-generating activities so they can resist coercive sexual advances that offer short-term financial benefits but have destructive long-term health effects. Young refugees need guidance, especially when family members have disappeared, and meaningful activity to occupy their minds and provide spending money. While income-generation projects normally do not take center stage in HIV prevention programming, they can help vulnerable sectors of the refugee population avoid risky coping strategies and protect themselves from infection.

Finally, coordinating the work of relief agencies and prevention programs is particularly important in a refugee setting. In the Ngara District, several organizations that share the same objectives were able to divide the tasks involved in both HIV/AIDS prevention and home care and to avoid duplicating efforts. Daily collaboration supplemented with weekly meetings has made such coordination possible.

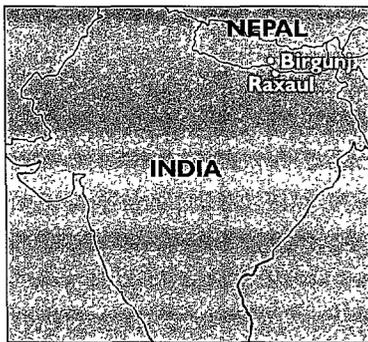
As the project matures, a greater understanding of how to help refugees prevent HIV infection is also evolving. With continuing unrest throughout the world and the growing international threat of the HIV/AIDS epidemic, sharing these insights will become more and more important.

Judy A. Benjamin is a medical anthropologist and international health consultant who served as CARE's refugee project director in the Ngara District of Tanzania from August 1994 to February 1996.

The India-Nepal Partnership

Building Cross-Border Collaboration in Areas of Affinity

by Mrudula Amin



Unlike national AIDS control programs, HIV does not respect national boundaries. Collaboration between HIV/AIDS prevention projects on both sides of the India-Nepal border offers a model for cross-border interventions to reach mobile populations at risk of HIV/AIDS.

At least a thousand Nepalese trucks were lined up at Birgunj, the checkpoint city on the Nepal-India border where the trucks' cargo is unloaded and reloaded onto Indian trucks. For Bhim, a seasoned Nepalese truck driver, this could mean days of waiting.

Away from the comforts and emotional support of home, Bhim was contemplating going to a sex worker for a few moments of pleasure when a stranger approached him. The stranger introduced himself as Kumar Das Manandar, a social worker from General Welfare Pratisthan, a local nongovernmental organization (NGO). Kumar's friendly approach persuaded Bhim to hear what he had to say about HIV/AIDS.

Bhim had heard about AIDS but

had not considered himself vulnerable. After Kumar explained that HIV is transmitted mainly through sexual intercourse and that the risk of transmission is greatly increased with multipartner sex, particularly if either of the partners has a sexually transmitted disease (STD), Bhim became worried and asked Kumar for advice. He was promptly referred to the STD clinic run by the Bhoruka AIDS Prevention (BAP) Project in Raxaul, a checkpoint city on the Indian side of the border. Without wasting any time, Bhim walked across the border to the BAP clinic.

At the BAP clinic two doctors—one male and one female—provide general medical services to truck drivers and others in the community, with an emphasis on STD treatment and HIV testing and counseling. Three social workers serve as

outreach educators for truck drivers waiting at Raxaul and also offer counseling in the privacy and comfort of the clinic. Dr. Asha Rao, director of the BAP Project, monitors clinic activities from Calcutta.

As chief of the Transport Corporation of India (TCI) blood banking service, Dr. Rao saw the "storm" coming before most others. In a seroprevalence (point prevalence) study conducted over eight weeks (October to December 1993) at a clinic in Ulubaria, West Bengal, 7 percent of the truck drivers tested positive for HIV. Further enquiry revealed that 25 percent of these truck drivers had no knowledge about condoms, 68 percent never used condoms, 94 percent sought sex from commercial sources when away from home and 84 percent reported histories of STD symptoms.

With these alarming statistics in



Outreach worker Mohan Mondal discusses HIV/AIDS prevention with truck drivers and their assistants at the Indian border.

hand, Dr. Rao convinced the management of TCI to offer voluntary HIV testing and counseling at an STD treatment center at the Ulubaria checkpost, a major intersection for trucks traveling from Calcutta to Nepal and Bangladesh. The client response was encouraging: Data collected at regular intervals during the first year of the intervention showed that the number of people seeking counseling and HIV testing increased from 136 to 2,431 and the number of condoms distributed upon request rose from 630 to 26,290.

Across Borders

The BAP Project in Raxaul is the result of a collaboration between the AIDS Control and Prevention (AIDSCAP) Project and Dr. Rao to expand TCI's initiative into a cross-border intervention. Research by

AIDSCAP—one of a series of studies of “areas of affinity” for HIV/AIDS prevention in Asia—had identified the trucking routes between Calcutta and Kathmandu as an important locus of high-risk sexual behavior.

In Asia, AIDSCAP has studied five areas of affinity that share common cultural, economic, demographic or epidemiologic characteristics. Most are linked by trucking routes, border zones or port cities with high concentrations of transport workers, business travelers, commercial sex workers, migrant laborers and other groups who may be at higher risk of acquiring HIV than more stable populations. Recognizing that the potentially deadly combination of mobile populations and a thriving sex industry drives transmission of HIV across national boundaries throughout the region,

AIDSCAP and the Asia Bureau of the U.S. Agency for International Development (USAID) are encouraging development of interventions that also cross borders.

On the Indian subcontinent, a natural place to reach mobile populations at risk of HIV are the “zero points” where a number of highways converge. An average of 2,000 trucks pass through these points every day, and truck drivers stop briefly for rest and refreshments.

A zero point for the National Highway 28 in India, Raxaul is the most important entry point into Nepal from India because it connects with Birgunj, the zero point for the Prithvi Highway in Nepal. Both Raxaul and Birgunj are big, sprawling cities, separated from each other by a few hundred meters. Traffic between the two cities is continuous, and visas are not required to go from

one country to another.

Raxaul was chosen as the most appropriate site for the cross-border intervention because it serves as a funnel for the trucks that transport goods between Nepal and India and because of its proximity to Birgunj, which is also one of the sites of an AIDSCAP-supported project implemented by General Welfare Pratisthan (GWP) in Nepal. The concept of linking two complementary prevention projects on opposite sides of the border was born.

Dr. Rao agreed to be director of the cross-border project at Raxaul in addition to her duties as manager of the Bhoruka Blood Bank, the leading blood screening, testing and storing facility in India. The Bhoruka Group is a subsidiary of TCI, the largest transport company on the subcontinent, with 1,500 trucks covering all of India. The Bhoruka Public Welfare Trust runs 15 dispensaries for truck drivers in various parts of the country.

Since Nepal's GWP had no Indian counterpart in Raxaul, the BAP Project could not build on existing local services. The Bhoruka Public Welfare Trust opened a new clinic in Raxaul and, with some difficulty, recruited medical staff and outreach workers who were willing to work in the remote checkpost town.

The BAP Project's clinic at Raxaul is the latest addition to the Bhoruka chain of clinics. AIDSCAP's role is to build capacity within the Bhoruka Group to develop, implement and monitor effective HIV prevention activities at Raxaul that can be replicated in Bhoruka clinics across India and to encourage collaboration between other HIV/AIDS prevention projects across the India-Nepal and India-Bangladesh borders.

Building a Partnership

To prevent the spread of HIV among the truck drivers and their assistants who regularly cross the India-Nepal border, the BAP Project collaborates

with AIDSCAP's partners in Nepal. At every stage of the project—planning, message and material design, training of field personnel and monitoring—the Indian and Nepali staff of the two projects work together to ensure consistency of project goals, evaluation indicators, strategies, messages and services on both sides of the border.

This consistency was an important factor in facilitating collaboration at the field level. Outreach workers from India and Nepal readily accepted each other as partners and found it easy to coordinate their activities because the projects had adopted similar approaches.

During the early stages of project start-up, BAP's project director met with AIDSCAP/Nepal's field staff to identify common areas of interest. Communication strategies, materials, training curricula and condom social marketing approaches developed for the Nepal program were reviewed jointly by staff from BAP, GWP and AIDSCAP/Nepal for applicability to the Indian setting (see p. 13). BAP followed Nepal's lead in designing STD training based on the syndromic approach recommended by the World Health Organization.

In the Field

Collaboration in the field began with the launch of the BAP Project. On September 11, 1995, the project organized an advocacy meeting at Raxaul to create awareness among various sectors of the community, including truck drivers, about HIV/AIDS. This meeting was planned jointly by field staff of the two projects, and resources from Nepal were shared with the Indian partners.

A crowd of about 1,000, including truckers, their assistants, local community leaders and schoolchildren, gathered in a cleared truck parking area for this inaugural advocacy meeting. The minister of health of Bihar state, the AIDSCAP

director, and USAID representatives from Washington and Kathmandu participated to endorse project goals and objectives.

Following this meeting, the two teams jointly implemented a number of events. On December 1, 1995—World AIDS Day—a rally was arranged by inviting participation from both sides of the border and involving local political leaders from Nepal. The Nepal Contraceptive Retail Sales (CRS) Company, which implements the condom social marketing project of AIDSCAP's program in Nepal, organized street theater and video presentations.

Before each collaborative event, GWP sends its Birgunj outreach team to plan and coordinate field activities with BAP staff. The Birgunj team and BAP Project staff visit each other regularly, and BAP personnel participate in staff training activities at GWP's Hetauda field office, just an hour's drive north of the border.

The most important part of the ongoing collaboration are the referrals from Nepal to India. Because STD services are not accessible in the Birgunj area, GWP staff refer men and women in need of STD services over the border to the BAP clinic, where STD diagnosis, treatment and counseling are available six days a week. GWP outreach educators provide dual-language referral slips to direct clients to the BAP clinic for an STD consultation and HIV/AIDS prevention education. Just three months after the clinic opened, it was receiving approximately 35 visitors a day.

Expanding the Model

This collaboration between HIV/AIDS prevention projects on both sides of the India-Nepal border is already attracting attention from policy makers concerned about the spread of HIV/AIDS among and by mobile populations. At a December 1995 meeting, the U.S. ambassador to Nepal, the chief of USAID's Of-

Office of Health and Family Planning in Nepal, AIDSCAP/Nepal's resident advisor, the director of the BAP Project and the communication officer from AIDSCAP's Asia Regional Office determined that the Raxaul-Birgunj collaboration should be expanded into a regional initiative.

As a result, AIDSCAP organized a three-day seminar on "Sharing Tripartite Experiences" from India, Nepal and Bangladesh. Held in Calcutta April 22-24, 1996, the seminar gave participants from government agencies, NGOs and the private sector in the three countries an opportunity to discuss the lessons learned from the Raxaul-Birgunj experience and to strengthen collaboration among USAID-supported HIV/AIDS prevention projects in the border zones.

Some of the key lessons identified during the seminar are as follows:

- HIV/AIDS prevention messages for people traveling across borders must be consistent.
- Interventions on both sides of the border gain credibility and community support if collaboration between field staff from the neighboring countries is observable at the field level.
- Collaboration between two neighboring projects is possible only if there is consistency in the strategic approach.

Seminar participants agreed on the need for complementary interventions to reach mobile populations on both sides of their borders. Building on the progress made during the tripartite meeting, AIDSCAP will continue to work with donors and NGOs to replicate the intervention in Raxaul and Birgunj, starting with the cross-border zone of Petrapol and Benapol on the India-Bangladesh border.

Mrudula Amin, MA, of the Program for Appropriate Technology in Health, serves as the communication officer in AIDSCAP's Asia Regional Office in Bangkok, Thailand.

A Logo for Both Sides of the Border

Cross-border HIV/AIDS interventions aim to maintain a seamless preventive environment for those who cross the border and linger in checkpoint towns. Exposing travelers to the same messages as they move from one country to another shows them that HIV/AIDS is not a "foreign" disease and that a sincere effort is made in both countries to prevent it.

The staff of the two HIV/AIDS prevention projects sponsored by AIDSCAP on either side of the India-Nepal border believed it was important to maintain consistency not only in the prevention messages being disseminated across the border but also in the image and tone of those messages. Thus, the Bhoruka AIDS Prevention (BAP) Project adopted the project logo developed by AIDSCAP/Nepal to use in posters, leaflets, stickers and counter displays.

A few changes were necessary to make the Nepal program's logo culturally acceptable to Indian sensibilities. The logo shows a condom named Dhaaley Dai fighting the HIV virus with a shield. (The program markets condoms under the brand name "Dhaal," or shield.) Focus group discussions held with Indian truck drivers to pretest the image revealed that they could not identify with the shield, which is a symbol of Nepal's legendary Gurkha soldiers. The condom figure's muscular arms and legs also were not appealing to the Indian men.

After revisions based on the pretesting, the logo designed for the BAP Project was similar to the Nepali animated condom, but without the shield and the muscular limbs. The eyes and nose on the condom also were modified to look more Indian. The messages, translated into Hindi, remained the same.

The pretesting and adaptation of the AIDSCAP/Nepal program logo for use in the BAP Project in India is one of many examples of the collaboration between the two projects. This collaboration enables project staff to communicate consistent yet culturally appropriate HIV/AIDS prevention messages among mobile populations along the border.



Top, AIDSCAP/Nepal's "Dhaaley Dai" logo. Bottom, the Indian version of "Dhaaley Dai."

—Mrudula Amin

Counseling and Testing for HIV/AIDS Prevention

by Raphael Tuju

The first randomized study of HIV counseling and testing may reveal whether they are effective as a catalyst for behavior change in developing countries.



Anne Kanjiri and her new husband Peter are participants in the counseling and testing study in Kenya.

When 22-year-old Anne Kanjiri, a resident of Nairobi, found out recently that she had tested negative for HIV, the news was more than just an opportunity to celebrate. It was a chance to make some changes in her life.

"I used to have many sexual partners before I was counseled and tested for HIV," she said. "When I got my results, I decided to get married instead."

To researchers from the Kenya Association of Professional Counselors (KAPC), Anne's response is as significant as the results of her test. Anne is a participant in the first study of the impact of counseling and testing (C&T) on behavior change for HIV/AIDS prevention among persons voluntarily seeking such service in developing countries.

Through randomized controlled trials conducted by the KAPC in Nairobi and by other centers in Tanzania, Trinidad and Indonesia, the

co-sponsors of the study hope to discover whether HIV testing accompanied by personalized, one-on-one counseling can influence individuals to adopt preventive behaviors and lower their risk of HIV infection.

Although C&T has long been an

■

Some in the HIV/AIDS prevention world wonder if C&T is too expensive to be sustainable, especially in poorer countries.

■

essential component of HIV/AIDS programs in developed countries, the study is the first large-scale randomized research on its effectiveness as a tool for behavior change in de-

veloping countries. A limited number of studies of C&T's impact on specific populations—discordant couples in Gambia, pregnant women in Rwanda, employees at a textile factory in Zaire, and so on—have yielded mixed results.

The lack of C&T data that can be generalized to a wider population is one reason why there's been so much debate over its value as a prevention strategy. Given how costly both HIV testing and intensive counseling are, is C&T too expensive to be sustainable, especially in poorer countries? Can it work where there is little early medical intervention available for those who test positive? Is there a sufficient supply of condoms within poorer countries to support C&T?

"One of the big issues these days is the best use of scarce resources for prevention and care," said Dr. Kevin O'Reilly, of the joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO). "C&T can be

more expensive and intensive than other prevention interventions, and it's crucial to have good information on its effectiveness so program managers can best decide how to use prevention funds."

The AIDS Control and Prevention (AIDSCAP) Project is funding the study at centers in Kenya and Tanzania, which began recruiting volunteers in June 1995. Funding for the centers in Indonesia and Trinidad, which opened in February 1996, came from WHO and UNAIDS. The Center for AIDS Prevention Studies at the University of California at San Francisco is coordinating the four centers, each of which will conduct the study for approximately 18 months.

Testing a Theory

C&T as a prevention intervention is believed to influence behavior in several ways. Knowing one's HIV serostatus could ease the anxiety of uncertainty and encourage better prevention and health maintenance behaviors. Early detection of HIV may also lead to referral to clinics for drug therapy, where it's available. Counseling could motivate risk reduction and present individuals with a range of choices for protecting themselves and their partners. Linking counseling and testing is thought to enhance the benefits of each.

To test these hypotheses, researchers first conducted formative research at the two African sites to develop culturally appropriate and methodologically sensitive surveys to gather information on sexual behavior, psychological status, knowledge and attitudes about HIV/AIDS and other sexually transmitted diseases (STDs), and care-seeking behaviors for STDs.

After pilot testing in April and May 1995 that led to some fine-tuning, recruitment of participants for the two sites began, primarily through radio and newspaper adver-

tising, posters displayed at workplaces and in public spaces, and one-on-one contacts. Over the course of several months, the response was impressive: 1,433 volunteers in Tanzania and 1,518 in Kenya. Initial interviews revealed an unexpected reason for the high turnout.

"I was pleasantly surprised to find that up to 86 percent of the people who came to the center in Kenya actually wanted to know whether they're HIV-infected," said Dr. Don Balmer, principal investigator at the Kenya study center. This challenges the popularly held belief that most people who suspect they have been exposed to HIV would rather not know their serostatus, he said.

At all four sites, the basic study protocol is the same, with minor adaptations to local conditions and culture. Participants are screened for information about sexual behavior, history of STD infection, and basic demographics, and are then divided randomly into two groups. Participants in the first group—known as the C&T group—receive pretest counseling and then are tested for HIV. After test results are available, each C&T participant receives personalized, interactive counseling, where individual life situations are

discussed as the context for prevention recommendations.

The second group—called the HIC group, for health information and condoms—is the control group. This group is not tested, and, instead of counseling, views a video offering culturally appropriate information on AIDS and STDs and receives free condoms plus training in how to use them.

Six months after the initial visit, participants from both groups come back for follow-up. At this point, participants in both groups are tested for STDs and offered the option of an HIV test with counseling, and participants with an STD receive free treatment. Researchers also administer a follow-up questionnaire that tracks the behavior change activities of both groups since the study began. A second and final follow-up takes place 12 months after recruitment.

Both C&T and HIC are potentially valuable tools for prevention, but the focus of each form of intervention is very different. HIC is designed to offer sound and understandable prevention information that is generalizable, but C&T goes much further by concentrating on individualized prevention and care strategies, as well as emotional and

ACE Communications



Counselors at the Kenya study center.

familial difficulties that may be caused by learning one's serostatus or by introducing prevention methods into a relationship.

For an uninfected client, these strategies can include condom use and discussing fidelity and other sensitive concerns with loved ones. For HIV-positive clients, there are other issues: how to avoid infecting others, how to make sure support and funds are available when illness finally strikes, how to protect against discrimination. Whether this fundamental difference in prevention approach affects how well people respond to the dangers of HIV may be one of the questions answered after data from the study are analyzed.



A lab technician at the Kenya study center screens blood samples of participants in the C&T group

Early Observations

With the African study centers facing the beginning of the 12-month follow-up period, and the other two study centers anticipating their six-month follow-up, it's far too early for results. But the research teams in Africa are already encouraged by the positive effects of the study on some of the participants in the C&T groups.

"One of every five adults we tested at this center is HIV-positive," said Francis Kihuho, the counseling director at the Kenya center in Nairobi. "The high number is depressing, but we are delighted every time someone comes back to tell us they have changed their behavior."

One example is Esther, a commercial sex worker who is a member of the C&T group in Nairobi. She says knowing her HIV-positive status and receiving one-on-one counseling helped her break through her fear and denial and decide not to give up on herself.

"I use condoms now, so I won't re-infect myself or infect anyone else," she said. "I used to suffer a lot from STDs, but not any more."

Dr. Gloria Sangiwa, principal investigator for the Tanzania center at the Muhimbili University College of Health Sciences, also has prevention success stories to tell.

"One couple came in for C&T, although the husband was initially reluctant, because the wife wanted to plan a pregnancy," said Dr. Sangiwa. "A few days later, the husband, now aware of the dangers of AIDS and the need for prevention, returned with his extramarital partner to request C&T for her."

"Unfortunately, the partner tested positive, but, despite the obvious emotional difficulties of the situation, the three are now planning both how to prevent further transmission and how to care for the girlfriend when she becomes ill," she added. "At the center, we think this is extraordinary."

Researchers are also learning

more about the difficulties individuals face when they learn their status and about the challenges that counselors encounter during individualized counseling. For example, when a participating couple chooses monogamy as a preventive strategy, new concerns surface.

"If this is the choice a couple decides to make, they face the fact that all sexual needs must therefore be satisfied within that monogamous relationship," said Dr. Balmer. "The specifics are sometimes hard for people to discuss, since in some Nairobi communities there's little vocabulary for discussing sex that's neither coldly scientific nor vulgar."

Dr. Balmer notes how emotionally draining one-on-one counseling can be for counselors in the study.

"We have weekly support meetings among ourselves, for what I would call 'emotional off-loading,'" he said. "We share the burden and support each other."

As work at each of the study sites wraps up throughout 1997, researchers will then turn to analysis of the data. Because of the geographic breadth of the study and the size of the study populations, AIDSCAP and UNAIDS expect the results to be significant for prevention programmers around the world. As funding for HIV/AIDS prevention worldwide shrinks, concerns about the costs of C&T will undoubtedly continue, but the bigger issue—whether C&T is effective, and ultimately worth the expense—may soon become clearer.

Raphael Tuju of ACE Communications in Nairobi, Kenya, has written extensively and produced several radio and TV programs on the social dimensions of HIV/AIDS in Africa.

Communication to Change Behavior

A Coordinated Approach to HIV/AIDS Prevention

by Donna Flanagan

Drawing on more than 25 years of experience in communication for development, behavior change communication programs go beyond information dissemination to give people the skills and support they need to protect themselves and their partners from HIV/AIDS.



Nick Shears

A Tanzanian woman talks to a co-worker about AIDS during a tea break. Nepalese truck drivers and commercial sex workers gather at a truck stop to watch a video about a rash young truck driver's assistant who learns about the risks of casual sex in hotels along the highway. NGO representatives meet with government officials in the Dominican Republic to present economic projections of the impact of the epidemic in their country during the next five years.

All of these activities are examples of behavior change communication (BCC) at work.

Of all the HIV/AIDS prevention strategies, BCC is perhaps the one people find most difficult to understand. Isn't it, some ask, just health education—or IEC (information,

Photo by Michael Buja/AIDSCAP



education and communication) by a different name? Isn't it really just posters and leaflets?

In fact, BCC is both an art and a science, using the results of epidemiological and social science research to guide the design of creative interventions that call on the talents of artists, writers, actors, producers, counselors and other communicators.

Above, a proposition in the schoolyard opens the Jamaican musical "Vibes," which encourages parents and children to talk to each other about sex, responsibility and HIV/AIDS. Left, the comic book character "Emma" provides advice about safer sex in ten countries.

Such interventions are an outgrowth of more than 25 years of U.S. Agency for International Development experience with development communication—also known as health communication, social communication, IEC, or community mobilization. The AIDS Control and Prevention (AIDSCAP) Project uses the term *behavior change com-*



A Nigerian peer educator demonstrates how to use a condom.

communication to emphasize the difference between simply providing information and giving people the knowledge, skills, encouragement and support they need for HIV risk reduction and healthy living.

True BCC activities for HIV/AIDS prevention use multiple channels to transmit and reinforce messages that address the needs of well-defined target audiences. They also give people the skills and tools required to prevent HIV and create a supportive social environment that helps people adopt and maintain safer sexual behavior.

But BCC cannot stand alone. It is an integral part of all the strategies that comprise AIDSCAP's comprehensive approach to HIV/AIDS prevention. Behavioral research and evaluation results are used to design BCC interventions that meet the needs of target audiences. BCC is an essential component of the policy process. And efforts to increase condom use, improve sexually transmitted disease (STD) control and change behavior are mutually rein-

forcing: BCC can persuade people to use condoms or seek STD treatment, and condom sales and STD services make it possible for people to act on BCC messages.

Responding to Real Needs
Behavioral research provides the starting point for risk reduction by

Formative research results make it possible to tailor the message, the communication channel and the strategy to address audience members' needs.

helping clarify risk behaviors and their determinants. It is the core of the formative research that is the basis of BCC interventions.

Because individual behavior is influenced by social, economic, political and cultural factors, formative research for BCC planning involves both community and individual investigation. The community investigation, or situation analysis, looks at societal factors such as the demographics of the target population, the economic factors that affect people's purchasing power, and the institutions and other forces that shape society's basic values. The individual investigation (audience research) explores target audience members' perceptions of such issues as HIV risk, the benefits of preventive measures, and the credibility and accessibility of potential sources of prevention messages.

When a BCC intervention is based on this type of information, it responds to the real needs of the target audience. Formative research results make it possible to tailor the

message, the communication channel and the strategy to address audience members' needs.

For example, students in Nigeria said they sometimes felt uncomfortable asking their peers questions about HIV, so the Nigerian Youth AIDS Program developed a radio call-in show to complement peer education efforts. Studies showing that Indian film stars were the most influential spokespeople in Madras led to the use of their voices in the voice-response system for an HIV/AIDS hot line. In Tanzania, the AIDSCAP-supported program emphasizes preventing STDs rather than HIV because key informants advised program planners that members of the target audience would be more receptive to such a message. STDs are common and familiar in the areas served by the project, but most people are afraid to admit that they might be at risk of HIV infection.

A comparison of AIDSCAP prevention projects for sex workers and their clients in the two countries that share the island of Hispaniola illustrates how very different approaches can be tailored to meet the needs of similar target audiences. In Haiti, where the sex industry is clandestine and many sex workers operate on the street or from their homes, NGO personnel usually contact sex workers privately and reach clients through workplaces. Printed materials are not widely used because neither clients nor sex workers want to be seen with them and because literacy levels are low. Videos, music tapes and interpersonal approaches have been more successful.

In contrast, the sex industry in the Dominican Republic is more open, and many sex workers work in bars. Both sex workers and their clients are reached through peer education conducted directly in bars and brothels. Printed materials are freely distributed and read.

Dramatic presentations in bars and on the streets stimulate open discussion of HIV/STD transmission and prevention.

Supportive Environments

By encouraging changes in cultural attitudes, social norms, and government and institutional policies, BCC campaigns can help create an environment that supports individual HIV risk reduction. Therefore, many BCC interventions are aimed at policy makers, religious leaders and influential community members.

Although conventional wisdom reminds us that information is not enough to help people change behavior, in the policy arena, carefully presented information can be the key to changing the thinking and actions of decision makers. Workplace managers may need to know about the projected financial costs of HIV/AIDS among workers to be convinced to support workplace prevention programs. Politicians may need to hear about the long-term effects of a duty tax on imported condoms before they are willing to devote resources to AIDS prevention. And teachers and parents many need facts about teenage sexuality to help them see the need for HIV/AIDS prevention programs



A sex worker pores over an HIV/AIDS prevention comic book in a Santo Domingo bar.

By encouraging changes in cultural attitudes, social norms, and government and institutional policies, BCC campaigns can help create an environment that supports individual HIV risk reduction.

in schools.

Again, it is the combination of art and science that makes for an effective BCC campaign targeted at specific decision makers with particular attitudes and distinctive information needs. Strategic presentation of this information may be as important as the information itself. Skillful communication is an important part of the policy process.

In Kenya, for example, clergy expressed concern about the lack of guidance from church leaders on pastoral counseling about HIV/AIDS. Results of a study sponsored by AIDSCAP and carried out by MAP International revealed that approximately half of church youth were sexually active and perhaps as many as one-third of clergy were not monogamous.

The study results were presented to church leaders at a national conference in Nairobi in February 1996. This information became the impetus for a commitment by the leaders to address the clergy's concerns. A statement of that commitment signed by leaders of six major reli-

gions and endorsed by other leaders was issued and printed in local newspapers. Leaders of these churches are now developing HIV/AIDS policies.

Links with Services

BCC is also intertwined with the HIV/AIDS prevention strategies of STD control and increasing condom accessibility and use. Condoms won't be used unless they are introduced and promoted. And they can't be successfully promoted without an understanding of the concerns and barriers that prevent sectors of the population from accepting them.

Audience research in Uganda determined that although sexually active young women wanted their partners to use condoms, they did not dare suggest it because of popular attitudes that associate condoms with commercial sex. To counteract this perception, the national AIDS control program designed BCC materials depicting savvy, popular young women buying and carrying condoms. In Haiti, Population Services International (PSI) produced a video to address women's concerns about negotiating condom use with their partners. The video shows ten different scenarios for sexual negotiation, based on audience research.

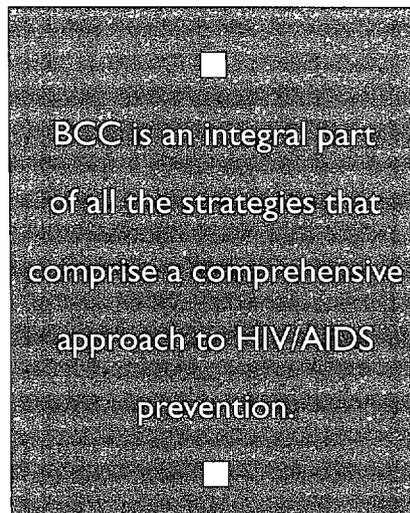
Similarly, people are not likely to take advantage of accessible and affordable STD treatment unless they can assess their own risk, understand the consequences, and be assured of professional, confidential treatment. Therefore, BCC targets potential STD patients and the health practitioners serving them.

In Ethiopia, for example, AIDSCAP supported targeted intervention research to learn about community members' understanding of STDs and their treatment. Results indicated that many respondents were reluctant to seek treatment for STDs because they feared rudeness and rejection by health care providers. Consequently, BCC

messages targeted both prospective clients ("Seek confidential and professional STD treatment at your local clinic") and health care workers ("Help your STD patients prevent further STDs by giving them time and understanding").

A Coordinated Approach

It is the art of BCC that attracts attention. Performances of "Vibes," a musical revue by the ASHE Caribbean Arts Ensemble in Jamaica, have delighted and informed thousands of young people and their parents. A "Love and Sex Fair," in Bangkok on Valentine's Day drew more than 2,500 people to compete in quizzes testing their knowledge of STDs,



watch condom demonstrations, and participate in frank discussions about sex, sexuality and reproductive health. Almost 1 million Haitians followed "Sultana Mon Amor," a television serial drama about a woman whose husband dies of AIDS. And Emma, the vivacious and supportive comic book character created by Family Health International's AIDSTECH Project (the precursor to AIDSCAP), has been used in ten countries. She now "speaks" five languages.

But it is the science behind these interventions—the painstaking audience research, systematic project

design, and coordination with interpersonal communication, condom distribution and STD services—that makes them work. The "Love and Sex Fair," for example, was a one-time event, but it was designed to reinforce the messages conveyed every day by hundreds of outreach workers and peer educators as part of the Comprehensive Bangkok Program. "Sultana Mon Amor" uses characters and situations familiar to the target audience to address barriers to behavior change identified by AIDSCAP's monitoring efforts.

This coordinated approach is evidenced throughout the AIDSCAP Project. In Jamaica, a project implemented by the Association for the Control of STDs (ACOSTRAD) includes condom social marketing, group educational sessions in STD clinics and outreach education by community members. The Organization of Tanzania Trade Unions (OTTU) works with parastatal and private sector company management in Tanzania to develop HIV/AIDS policies, support peer education programs, and distribute condoms in workplaces. And in Bangue, Thailand, the World Vision Foundation of Thailand trains and supports peer educators, pharmacists and government health center and STD clinic staff to improve STD services and promote behavior change.

While BCC planning and principles are fundamental to all of these projects, it is the provision of goods, services and skills training that permit people to adopt the behaviors advocated in BCC messages. Helping people move from unsafe to safer behaviors is a complex task that can only be accomplished through concerted efforts to master both the science and the art of behavior change communication.

Donna Flanagan, MA, MSW, is AIDSCAP's associate director for behavior change communication.

Condoms are now
appearing in places
they've never been
seen before.

Casting a Wider Net

Improving Access to Condoms

by Margaret J. Dadian

In a dusty marketplace in Port-au-Prince, an itinerant vendor arranges her wares on a small table: combs, soap, cigarettes — and bright yellow packets of condoms.

In a tiny Kathmandu shop barely bigger than a phone booth, a merchant decorates the wall with colorful condom packets strung up like holiday lights.

And in downtown Nairobi, young people in blue uniforms gather before setting off on bicycles to sell condoms around the city.

A few years ago, such scenes didn't exist. In many developing countries, condoms were available only at family planning clinics and pharmacies, during limited hours, to a limited clientele.

The HIV/AIDS epidemic changed that forever. Because condoms remain the only proven method of preventing HIV transmission in sexually active populations, promoting condom use has become a central effort for prevention projects around the world. Successful promotion and mass marketing ventures have raised demand for condoms, making it critical to increase their

accessibility wherever people live, work, shop and seek entertainment.

"The key to AIDS prevention is getting condoms to the people who need them," said Richard Frank,

president of Population Services International (PSI), which works with the AIDS Control and Prevention (AIDSCAP) Project in social marketing of condoms for HIV/AIDS prevention in developing countries.

"The traditional method of selling condoms only through pharmacies and clinics greatly constricts distribution," said Frank. "It narrows the number of outlets dramatically and limits availability for many segments of the



Fishing boats in Bangladesh spread the word about Raja condoms to riverside communities.

population.”

Condoms are now appearing in places they've never been seen before: at a kiosk by a Brazilian beach, in the cloth rucksack of an itinerant Bangladeshi poet, or on board a small boat catering to riverbank dwellers in Zaire. Whether the outlets are stationary—a tea shop in Phnom Penh—or mobile—a motorbike salesman in rural Haiti—the result has been tens of millions of new condom sales worldwide and, it is hoped, many HIV infections averted.

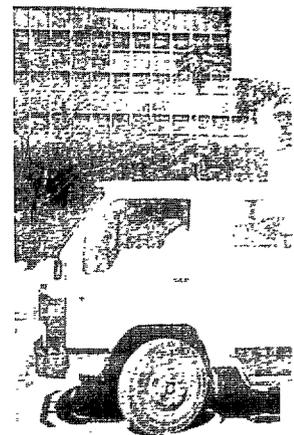
In Haiti, for example, sales figures have risen some 200 percent since PSI introduced the Pantè condom in 1990, despite several years of social upheaval and an international fuel embargo that choked most commercial distribution throughout the country. More than

15 million Pantè condoms were sold between 1990 and 1995.

A wider variety of sales outlets for condoms also means more opportunities to teach people why and how to use them. Pamphlets and brochures are often available at sales points, and at some outlets—such as the beach kiosks in São Paulo—health educators demonstrate correct condom use and encourage safer sex behavior. Spontaneous discussions about condoms and HIV/AIDS prevention

often break out among shoppers viewing a sales display. Even when no sale takes place, the increased public exposure is beneficial in itself.

“One important reason for broadening the number and kind of condom outlets is that individuals see the product and become sensitized to it,” said Richard Frank of PSI. “Eventually, the message gets across that condoms are part of everyday life—an everyday means of saving your own life.”



In Haiti, this Pantè vendor can cover miles and reach dozens of customers on his scooter.

PHOTOGRAPHS BY POPULATION SERVICES INTERNATIONAL

Right, with the help of team members and the smiling Mr. Lover Man mascot, a soccer match in Lesotho becomes an opportunity to promote and sell condoms.



On the Move

All photos by Population Services International, unless indicated

In the Community

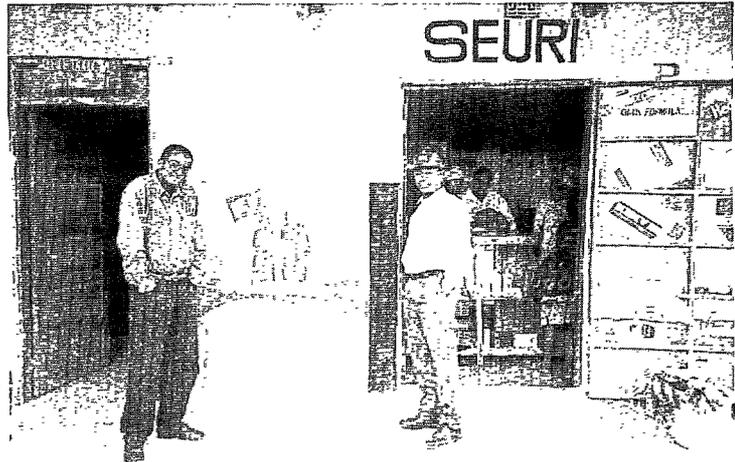


Left, young bicyclists in Nairobi, Kenya, are part of a mobile condom sales squad that covers a wide part of the city each day

In Tanzania, a mobile video unit presents safer sex videos to communities without radio or television while condoms are sold from the back of the truck.

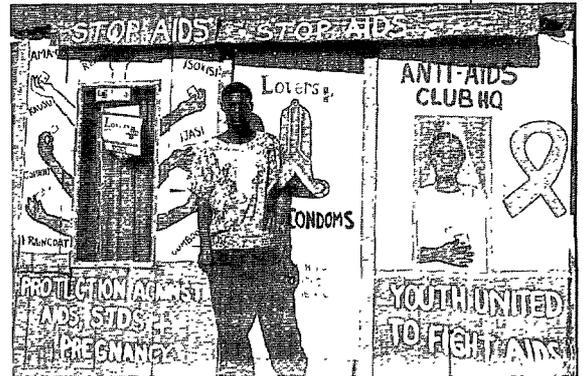


On a Tanzanian shop wall, the Salama condom ad dwarfs ads for all other products.



Jonathan Kirn/DKT do Brasil

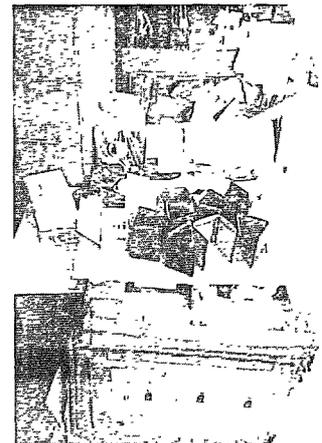
Below A health educator at a São Paulo beach sales kiosk makes change for a customer.



Above, In South Africa, a young people's anti-AIDS club uses a colorful display of condom slang to encourage sales.

Below left A Nepalese shop owner strings up bright red Dhaal brand condoms to compete in a display contest

Below: In Haiti, poor vendors increase their income by selling condoms in the marketplace.



Public Health Approaches to STD Control

New Challenges in the Era of AIDS

by Margaret J. Dadian

An increasing understanding of the links between HIV and other sexually transmitted diseases has led to an emphasis on more community-oriented STD prevention and treatment strategies.

In the fifteenth century, when Europeans first began to recognize the existence of sexually transmitted disease (STD), patients suffering from syphilitic ulcers were offered a special cure for their malady. It consisted of a toxic salve of mercury, pork fat, vinegar and sulfur rubbed deep into the sores, followed by 30 consecutive days of hard sweating in a steam room—a remedy usually more lethal than the disease itself.¹

It took 500 more years for scientists to find a better alternative in antibiotics. By that time, a revolution in thinking about the causes, the treatments and the social meanings of STDs had occurred.

During the past decade, medical and social responses to STDs have evolved again, provoked by the emergence of the HIV/AIDS epidemic. As evidence builds that STD

infection may increase transmissibility of HIV as much as ninefold, greater attention is being paid to STD control—and new approaches are emerging that could significantly expand the scope and the scale of STD treatment and education in developing countries.

“We’re turning from a clinical orientation, which limits the focus to the individual STD case, to a public health approach, which deals with STDs as a community health problem,” said Dr. Gina Dallabetta of the AIDS Control and Prevention (AIDSCAP) Project.

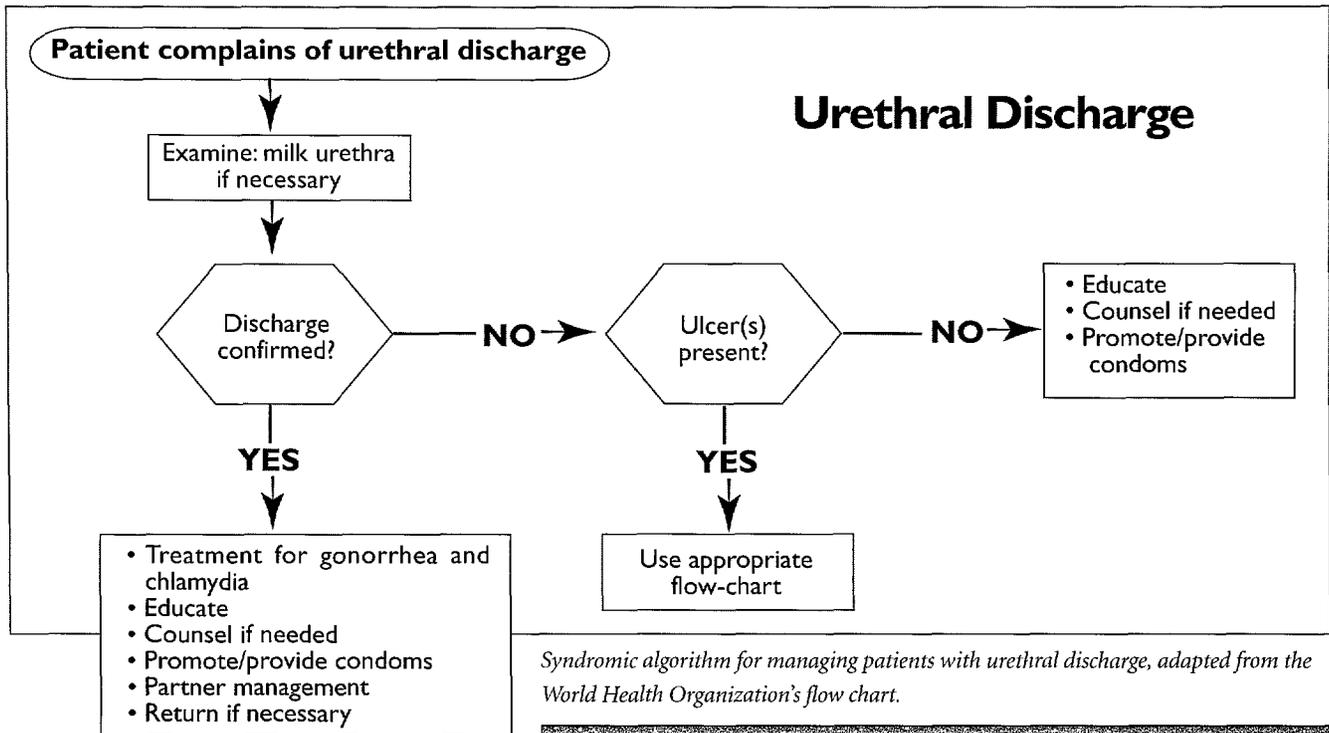
STDs in Developing Countries

Among women in developing countries, syphilis prevalence rates may be 10 to 100 times higher than in developed countries; gonorrhea rates may be 10 to 15 times higher. One study in Kenya showed that 23 per-

cent of women ages 15 to 19 seeking care at an antenatal clinic suffered from gonorrhea, chlamydia or herpes. In many of the same countries—particularly in Africa—HIV infection rates are similarly high, and researchers are trying to explain why.

“We’re noticing that HIV-positive people who have other STDs are simply more infectious,” said Dr. Myron Cohen, a microbiologist who is chief of infectious diseases at the University of North Carolina Medical School. “For example, preliminary findings on seropositive men show that those with untreated urethritis shed far more viral particles than those without another STD.”

Epidemiologists are also building impressive evidence revealing the linkages between HIV and other STDs. Findings from a pathbreaking prevention study conducted in



Mwanza, Tanzania, confirm that improved treatment of STDs can reduce the incidence of HIV infections. During the two-year study, broad-scale treatment of STDs within a cohort of 1,000 using the least expensive effective drugs led to an astonishing 42 percent decline in new HIV infections.

Results like these offer considerable incentive to make improved STD prevention and treatment a primary HIV prevention strategy. But for developing countries, where resources are scarce, pursuing such ambitious public health goals is difficult.

The etiologic diagnosis of STDs that is standard throughout wealthier countries requires diagnostic tests, well-stocked laboratory facilities and highly trained medical personnel—resources that many poverty-stricken countries cannot

afford. Clinical diagnosis, based primarily on visual cues and the practitioner's prior experience and knowledge, is inexpensive but unreliable in differentiating between STDs. Many of the antibiotics required for STD treatment are also expensive and often unavailable in developing countries. Developing diagnostic and treatment alternatives that are both accurate and affordable has become a priority for STD/HIV prevention efforts.

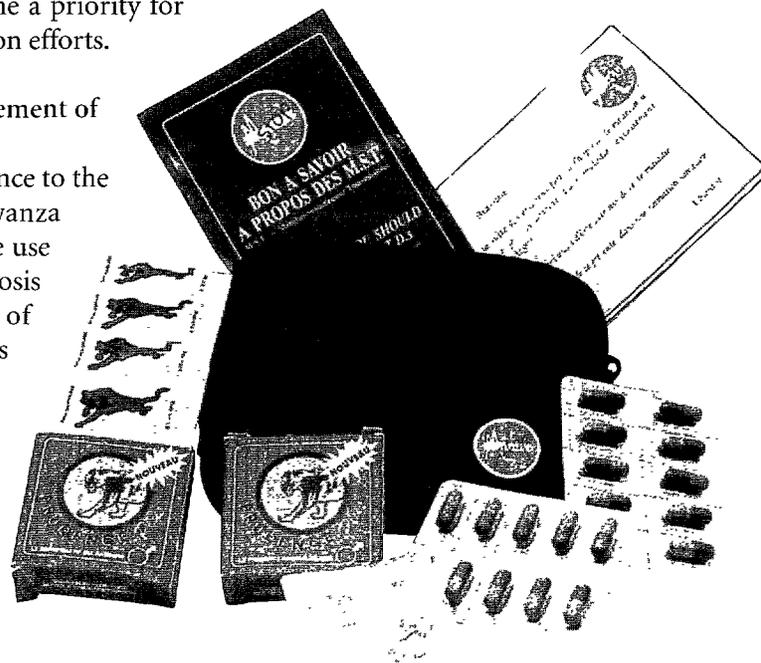
Syndromic Management of STDs

Of central importance to the success of the Mwanza experiment was the use of syndromic diagnosis and management of STDs in the region's health centers. First formulated

by World Health Organization (WHO) experts in the late 1980s, the syndromic approach offers treatment for the most common causes of STD syndromes (sets of symptoms) when the patient first seeks medical care. Rather than order expensive and time-consuming lab tests to pinpoint the pathogen causing the syndrome—say, genital ulcers—the practitioner prescribes all

The M-STOP kit of prepackaged STD therapy, which was field tested in Cameroon, contains antibiotics, instructions, an informational brochure, two partner referral cards and eight Prudence condoms.

Steve Mobley



the antibiotics and therapies necessary to treat all locally prevalent STDs that could create ulcers, such as chancroid and syphilis. With every causal base covered, the likelihood of a cure rises dramatically.

“In the absence of resources to provide more specific diagnoses through lab testing, syndromic management allows clinicians to maximize their bets when they place patients on treatment regimens,” said Dr. Willard Cates Jr., Family Health International’s corporate director of medical affairs.

In resource-poor settings such as the Tanzanian countryside, the benefits of syndromic management are many. First, precious health care funds need not be spent on lab tests which, depending on the country’s technical resources, may not even be reliable. Second, one-stop treatment solves a problem endemic to developing countries: patients who are too anxious, too busy or too poor to return for follow-up. Third is the opportunity for syndromic management practitioners to give face-to-face prevention counseling and training in condom use and other prevention methods to patients, the final step in most syndromic protocols.

A fourth advantage is that the syndromic method does not require costly graduate-level medical education. Less-skilled health workers as well as physicians can be trained in the method, which uses simple flow charts to guide the practitioner to the proper diagnosis and treatment.

The AIDSCAP Project, WHO, the joint United Nations Programme on HIV/AIDS (UNAIDS), the Pan American Health Organization (PAHO) and other international health agencies are working with governments and nongovernmental organizations (NGOs) to actively promote syndromic management. Frequently, they encounter resistance.

“Developing countries have a



A woman and children wait for their medicine at a local drug store in Peru. To avoid long waits at clinics, embarrassment and expense, many people self-treat STD symptoms with drugs bought from pharmacists, traditional healers or local vendors.

tendency to believe that development means acquiring more sophisticated technology—which to them means testing,” said Dr. Cohen. “It becomes a matter of convincing health ministers and national medical associations that, in the case of syndromic management, what they might see as ‘less’ really is more.”

Other obstacles can slow the

adoption of syndromic management. Baseline research is needed to determine the algorithmic protocols, which differ from place to place depending on which STDs are locally prevalent. Regional data on the effectiveness of antibiotics for specific STDs also must be gathered. Another major challenge is getting all parties in the health care and

STD/HIV prevention community to the table to agree on national protocols.

In Haiti, a country beset by political unrest and widespread poverty, giant steps have been made toward adopting a single set of guidelines for syndromic management. A working group of health agencies and NGOs, including AIDSCAP, the University of North Carolina, PAHO, an NGO coalition from the Central Plateau region, the Cornell-GHESKIO research group and the Centre pour le Développement et la Santé shared observations from their clinics and used the results of a 1993 baseline study to reach a consensus on syndromic management guidelines.

AIDSCAP, a major proponent of syndromic management, has been involved in the research, promotion and facilitation of similar efforts to create national syndromic guidelines and improved care at points of first encounter in 19 countries throughout the developing world.

Improving Drug Delivery

All too often, self-treatment is the route that many STD patients in developing countries take to avoid hours spent in clinic waiting rooms, embarrassment at being seen at STD clinics, and high doctor's fees and prescription costs. They may feel more comfortable asking pharmacists, traditional healers, street peddlers and even friends and family members for treatment suggestions.

The dangers are obvious. Misdiagnosis of one's own STD means that it's unlikely the drug the patient finally takes will be effective. Most poor patients can't afford a complete course of antibiotics, and buy amounts insufficient to treat the STD. The drugs they're told to buy may not work at all because their STD is resistant to the antibiotic. The STD is never cured, and the patient may unknowingly infect others while suffering ever more se-

rious damage from the disease.

One innovative solution is pre-packaged drug therapy for STD syndromes, available by prescription or over the counter from pharmacists trained to diagnose symptoms and provide counseling. The *M-STOP* pilot project in Cameroon, a joint effort of AIDSCAP, Population Services International and the Institute of Tropical Medicine, offered attractive, affordable kits containing antibiotics, condoms, informational



As evidence builds that STD

infection may increase

transmissibility of HIV as

much as ninefold, greater

attention is being paid to

STD control.



brochures, instructions and other materials to men with symptoms of urethritis.

The project soon ran into difficulty when supporters at the Ministry of Health were replaced by skeptics who limited *M-STOP*'s distribution to a handful of health clinics serving very specific populations. Resistance from health care providers at some of those clinics further limited use of the kits.

With lessons learned about how to gain greater acceptance from the medical community and health officials, AIDSCAP is now working with the Nepalese Chemists and Druggists Association, donor agencies and NGOs to implement a pre-packaged drug therapy project in nine districts in the Central Region of Nepal. Research has shown that a high percentage of STD cases in

Nepal are treated by chemists (pharmacists) and other health providers outside the national system of clinics and hospitals. Nepalese officials and health leaders, whose support was recruited as early as possible, are collaborating with enthusiasm in project planning.

Other pharmacy-focused approaches are being tested in developing countries. In Thailand, where pharmacists are frequently consulted by patients with STD symptoms, AIDSCAP and the Program for Appropriate Technology in Health (PATH) conducted a pilot project to train pharmacists and drugstore staff in STD diagnosis and drug prescription. AIDSCAP and PATH worked closely with two pharmacists' associations in Chiang Mai province to develop training activities that improved pharmacists' ability to manage STD cases. The project has inspired pharmacist training efforts by the European Community and other donors in Thailand.

Identifying Community Needs

Community acceptability is key to program success, and STD prevention programmers who understand local belief systems and cultural perceptions about illness, health-seeking behavior and STD infection can design more effective interventions. A rapid ethnographic methodology called targeted intervention research (TIR) can help researchers identify community attitudes that may help or hinder STD treatment and promotion of such prevention methods as condom use.

The TIR, developed by AIDSCAP in collaboration with researchers from Johns Hopkins University and the University of Washington, is based on interviews and focus group discussions with STD patients and with people living in communities served by STD programs. Unlike traditional ethnographic surveys, the TIR is targeted to answer specific programmatic questions. AIDSCAP

has used the TIR successfully in Senegal and Ethiopia to study health-seeking behavior, in Zambia to design communication strategies promoting early attendance at antenatal clinics, and in the Philippines to understand how commercial sex workers avoid STD infection.

Such research is particularly valuable for formulating STD prevention and treatment programs for vulnerable “core” groups within communities. Because certain members of a population may be at higher risk for STD/HIV infection, it often makes public health sense to target limited resources in developing country programs to those sectors.

In identifying priority groups, though, it is critical to avoid stigmatization. Education and treatment projects for commercial sex workers (CSWs), for example, must be designed so that clients feel their privacy and confidentiality are guaranteed. The location and hours of service must be convenient, and the atmosphere should be comfortable and non-threatening. Early input from CSWs on such matters is one way to design successful projects from the start.

Many CSWs prefer brothel-based services because they are convenient and are more likely to be private and confidential. In Thailand, the Philippines and Indonesia, some brothel owners contract with private practitioners to attend CSWs regularly on site. In Mali, a visiting medical team provided care at brothels during hours that did not interfere with the women’s work. To curb stigmatization, the team traveled to each site in buses or taxis rather than easily identified government health vehicles.

Not all successful services for CSWs are brothel-based, though. With intelligent and successful design based on input from CSWs, other kinds of sites—primary health care and family planning clinics,

mobile vans, private medical facilities—will be acceptable, leading to lower HIV/STD infection rates among CSWs and thus the community at large. These design and planning principles are also successful with other hard-to-reach groups, such as youth and persons working away from home.

Community input of another kind is also critical to success in curbing STDs. Partner notification and referral by STD patients can dramatically increase the number of infections treated within a given community. Referral is especially valuable for reaching infected women, many of whom have no STD symptoms.

In Rwanda, for example, STD patients involved in a special study conducted by Rwandan and U.S. re-

■

“We’re turning from a
clinical orientation, which
limits the focus to the
individual STD case, to a
public health approach,
which deals with STDs
as a community health
problem.”

■

searchers were counseled and then given referral coupons for their sex partners. The coupons offered a free STD exam and treatment, and were coded so that clinic staff knew which treatment to give the partner based on the first patient’s infection. Not all patients were willing to give the coupon to their partners—and not all partners who were given them

were willing to seek treatment—but a significant number of partners who might not have sought treatment or have even known they were infected used the coupons.

The Challenges Ahead

STD prevention programs in developing countries continue to struggle with deep-seated structural problems. Many infected women are completely asymptomatic, and may suffer permanent and painful damage to their health and fertility and to their newborns’ health because they don’t know they need treatment. The drugs critical for STD treatment can be unaffordable for the health systems in developing countries, and, as STD strains become increasingly resistant to available antibiotics, replacing those medications with newer and more powerful ones will be even more costly.

Some researchers and programmers also fear that the drive to prevent and treat STDs has lost its public focus because of the far more attention-grabbing and well-funded international campaign to curb the spread of HIV. Others, though, are optimistic that the experience, knowledge and perspective acquired in recent years because of the threat of the HIV/AIDS epidemic will ultimately benefit STD prevention efforts.

“It’s not easy to explain why we didn’t use the public health approach to promote some of these innovative STD prevention and treatment methods before AIDS appeared,” Dr. Cohen said. “But now we can build on what we’ve learned and expect to see positive results.”

References

1. Marantz, Robin. The Lessons of Syphilis in the Age of AIDS. *Civilization Magazine*, November-December 1995, pp. 36-43.

Evaluating HIV/AIDS Prevention Programs

Meeting the Challenge

by Kathleen Henry

Measuring sexual behavior resulting from HIV/AIDS prevention programs is a difficult undertaking. With its emphasis on evaluation beginning with project design, the AIDSCAP Project offers a unique opportunity to test innovative approaches to evaluation.

In 1996, the AIDS Control and Prevention (AIDSCAP) Project began the final phase of an ambitious effort to evaluate the progress of its HIV/AIDS prevention programs. As part of the final evaluation of comprehensive programs in 18 countries, tens of thousands of people will be interviewed and hundreds of group discussions held.

But the sheer quantity of the data is only one of the challenges facing AIDSCAP evaluation specialists. For the past decade, HIV/AIDS program evaluators throughout the world have been wrestling with some difficult questions. How can they track changes in people's most private behavior? Without reliable HIV incidence data in most countries, how can they be sure that prevention interventions have had an impact? And, when changes in behavior or disease rates are detected, can they be attributed to the actions of one program or project?

AIDSCAP evaluation specialists

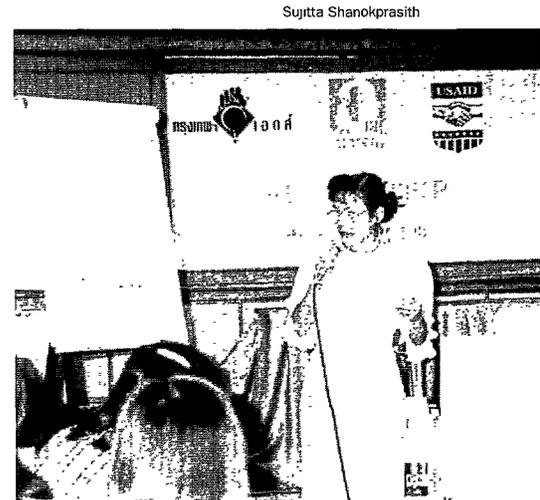
started searching for answers to these questions when the project began in 1991. Specific objectives and ways of measuring whether they have been met are built into the design of every country program and each of the "subprojects" that comprise that program.

"Most evaluation processes are post hoc," said Dr. Susan Hassig, former associate director for evaluation at AIDSCAP. "Considering evaluation in the design of the project at all levels shouldn't be innovative, but unfortunately, it is."

Although monitoring and evaluation have been part of the project from the start, AIDSCAP's approach to evaluation has evolved over the past five years as more has been learned about the complex behavioral, social, economic and cultural factors that drive the HIV/AIDS epidemic—and about the limitations facing evaluators.

Measuring Success

Most disease control programs use



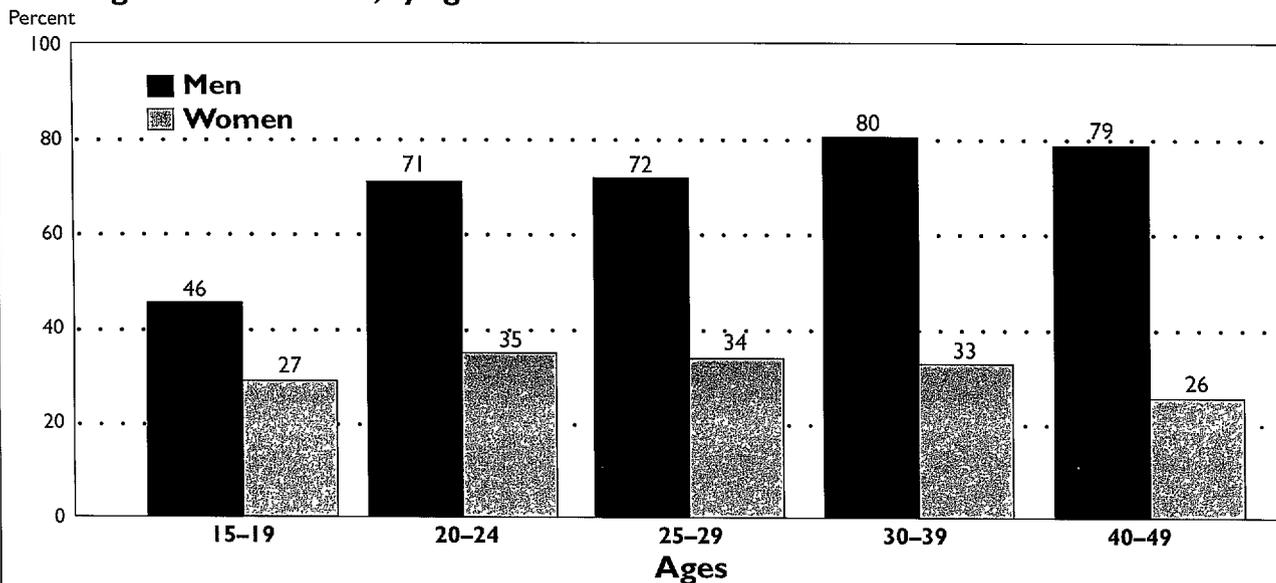
Apa Youngpradith of the Bangkok Metropolitan Authority gives a presentation at AIDSCAP's workshop on behavioral surveillance.

biological indicators to monitor and evaluate progress. But for HIV/AIDS, biological data are either unavailable in most of the developing world or of limited value for evaluating progress against the epidemic.

Some developing countries have fairly accurate information on the level of HIV infection in subsets of their populations at a given time. However, because these prevalence data can represent infections that occurred six months to ten years earlier, they do not necessarily reflect change or lack of change in risk behavior.

Rates of other sexually transmitted diseases (STDs) can be proxy indicators of changes in sexual behavior but must be interpreted with

Percentage of Haitian men and women who have changed their behavior since hearing about HIV/AIDS, by age



Evaluation results in Haiti found that people's reactions to HIV/AIDS interventions varied greatly by sex and age.

caution. STD statistics seldom capture all or even most STD cases because many people seek treatment outside the formal health sector and many health information systems are weak.

The most useful kind of biological data for evaluating the impact of HIV/AIDS prevention interventions are rates of new HIV infections. Such incidence data are rarely available because it is so difficult and expensive to collect them.

Demonstrating a meaningful reduction in HIV/AIDS transmission would require large sample sizes and high initial incidence rates in the target population, explained Dr. Daniel Tarantola, director of the International AIDS Program at the Harvard School of Public Health's François-Xavier Bagnoud Center for Health and Human Rights. Given all the constraints, he believes that using biological indicators to measure the impact of most HIV/AIDS programs is "both unrealistic and impractical."

Assessing Behavior

In the absence of reliable biological

data on HIV/AIDS and STDs in most countries, behavioral indicators are the most important measures of progress in HIV/AIDS prevention. Because people throughout the world find it difficult to talk about their own sexual behavior, evaluating whether behavior change is occurring requires creativity and patience.

Like most health campaigns to change behavior, HIV/AIDS prevention programs must rely on people's own reports of their behavior. Although concerns about the accuracy of data on self-reported behavior is warranted—particularly when the

subject is sexual behavior—it is possible to design internal and external checks to ensure that the information is valid and reliable. Examples include phrasing the same question several different ways, using different methods to collect the same information and, where appropriate, comparing respondents' answers with those of their partners.

A more difficult challenge for HIV/AIDS evaluators is detecting whether any behavior change has occurred over a relatively short period. A typical prevention project lasts two to five years, but the experience of anti-smoking and family planning campaigns has shown that behavior change can take decades.

After five years or less, "we may not see huge amounts of change," noted Dr. Jan Hogle, AIDSCAP evaluation officer. "Change occurs in incremental steps, and we need to figure out how to capture those intermediate steps."

Making a Difference?

Ultimately, the question everyone is most interested in answering—"What difference did the interven-

■

The experience of

anti-smoking and family

planning campaigns has

shown that behavior change

can take decades.

■

tion make?”—may be the most difficult one to answer. Because behavior is influenced by so many factors, it is impossible to attribute changes in behavior to the efforts of one program.

Attribution is also difficult because the epidemic has its own dynamic. “You don’t know what would have happened without your intervention,” said Dr. Tobi Saidel, AIDSCAP evaluation officer.

The only way to overcome these difficulties—a study with a randomly selected control population that does not receive any prevention services—is an expensive undertaking that does not always reflect the reality of an actual prevention program, not to mention the ethical dilemma it poses.

“Every donor, every NGO, every implementor of an HIV prevention project wants to know that his or her project is having an effect—that’s human nature,” said Stephen Mills, epidemiologist and evaluation officer in AIDSCAP’s Asia Regional Office in Bangkok, Thailand. “Unfortunately, implementing the kind of rigorous study that has the power to say that your intervention has had that effect could double or triple the cost of the intervention.”

To demonstrate an association between AIDSCAP interventions and behavioral or HIV/AIDS trends among the project’s relatively small target populations would require a particularly complex study, noted Dr. Tarantola, who served on an independent team that conducted AIDSCAP’s midterm evaluation for the U.S. Agency for International Development in 1994-95. “The danger is that the research objective would supersede the prevention objective,” he added. “AIDSCAP’s focus is naturally on prevention.”

What AIDSCAP and other project evaluators can do instead, explained Dr. Thomas Rehle, AIDSCAP’s new associate director for evaluation, is use multiple meth-

ods of evaluation. The information from these sources can be “triangulated” to gain as complete a picture as possible of what is happening in the field. AIDSCAP uses a variety of methods to achieve this goal, including process monitoring, surveys, focus group discussions and in-depth interviews.

Monitoring the Process

The most basic form of evaluation is process evaluation—monitoring whether a project is doing what it is supposed to do. AIDSCAP developed a standard set of indicators, such as number of training sessions held, number of people educated and number of condoms sold or distributed, and a decentralized reporting system to monitor implementation of each subproject and country program.

The almost 300 agencies that implement AIDSCAP subprojects submit monthly “process indicator forms” (PIFs) to report on their progress toward reaching the targets specified in their project plans. These standardized forms make it possible to aggregate seemingly disparate data from many projects for

program-wide reporting and feedback to the field.

At first field staff found this system too time-consuming, but many project managers now consider the PIFs a valuable monitoring tool. In fact, when evaluation associates from AIDSCAP country offices were given the option of reporting quarterly rather than monthly process data, they said they preferred to submit monthly reports.

Understanding the Numbers

AIDSCAP evaluation specialists monitor biological indicators when data are available, but rely primarily on behavioral indicators to track trends that reflect the influence of a variety of interventions. For each program and subproject, they look at changes in behavior known to reduce the risk of HIV transmission, such as consistent condom use and having fewer sexual partners.

Quantitative information on behavior is collected primarily through knowledge, attitudes, beliefs and practices (KABP) studies conducted among target audiences. To gain a better understanding of this information, AIDSCAP also uses meth-

VDP



An HIV/AIDS education session with youth sponsored by Volontariat pour le Développement d’Haiti. Evaluation results from Haiti suggest that knowledge of HIV/AIDS is widespread, but condom use lags behind because many people do not perceive themselves to be at risk.

ods that produce more qualitative information, such as in-depth interviews, focus group discussions and observation.

“Generally people think of evaluation as numbers and percentages,” Dr. Hassig noted. “What we’ve found is that especially with HIV, the qualitative information is extremely important to understanding what the numbers actually mean.”

AIDSCAP’s emphasis on qualitative data is one of the most exciting aspects of the project’s evaluation strategy for Maxine Wedderburn of HOPE Enterprises, the private research organization responsible for monitoring and evaluating the AIDSCAP program in Jamaica. “There is such a richness coming out of the qualitative work,” she said, noting that many of her company’s clients consider qualitative research a “luxury” they cannot afford.

Wedderburn believes that using qualitative methods is particularly important in HIV/AIDS evaluation because of the sensitive nature of the subject: personal sexual behavior. In-depth individual and peer group discussions allow time for participants to develop confidence and trust in interviewers or facilitators. The result, she said, “is more rapport—which leads to more disclosure.”

Qualitative information can help evaluators understand why certain interventions were effective and others were not. It can identify barriers to behavior change and suggest ways to improve prevention efforts.

In Haiti, for example, women factory workers talked about using family planning as a strategy for discussing condoms with their husbands. And conversations with Haitian men suggest they were willing to talk to their wives about condoms because the women had learned how to use them from an HIV/AIDS prevention project—rather than from another man.

In Nepal, qualitative research led

to an important change in the AIDSCAP program plan. The original plan was to reach two important groups—truck drivers and commercial sex workers—in towns along major highways. But interviews and a mapping exercise revealed that the truck drivers prefer to patronize sex workers in tea shops, restaurants and lodges in remote areas where it is easier to park and the police are less likely to interfere. As a result, project activities targeting truck drivers and their partners center

■

In-depth individual and
peer group discussions allow
time for participants to
develop confidence and
trust in interviewers or
facilitators.

■

around the smaller commercial centers and rest stops the truck drivers marked on road maps of Nepal.

Beyond PIs

The starting point for many AIDSCAP evaluations is the priority indicators (PIs) it helped the World Health Organization develop to encourage standardized reporting on HIV/AIDS prevention projects worldwide. In most cases, since these indicators are basic measures for national programs, they have to be adapted for AIDSCAP’s smaller-scale interventions with more specific target audiences.

AIDSCAP is also developing indicators that are more gender-sensitive to gain a better understanding of the impact of HIV/AIDS prevention interventions on women. For example, two of the ten priority

indicators are designed to track changes in condom use with “nonregular” partners and in numbers of nonregular partners. But there is increasing evidence that many women who have only one sexual partner are at risk of HIV infection as a result of that partner’s behavior.

Instead, to assess HIV/AIDS prevention interventions with these women, AIDSCAP prefers to ask them whether they think their husbands have other sex partners. Women who answer yes to this question are then asked about their perceptions of personal risk, condom use and other changes in sexual behavior, including whether they are able to negotiate condom use with partners.

Another limitation of most measures of the impact of prevention interventions is that they focus on knowledge of HIV/AIDS and adoption of preventive behaviors. Experience has shown that knowledge is only the first step in a gradual process that leads to behavior change. Most evaluation efforts miss the steps in between.

To capture those small but critical changes in people’s behavior, AIDSCAP evaluation specialists have developed a list of intermediate behavioral indicators along a continuum from acquiring knowledge to adopting and maintaining a new behavior. The indicators include perception of individual risk of HIV infection, intention to do something to reduce that risk, and having discussed HIV/AIDS and other STDs with sexual partners.

These intermediate behavioral indicators re-emphasize the importance of information that is already available, explained Joseph Amon, AIDSCAP associate evaluation officer. “We are collecting the information, but people aren’t always looking at those questions,” he said. “They’re looking at the end-stage indicators.”

BSS: Tracking Trends in Sexual Behavior

Throughout Bangkok, in offices, factories, gas stations, brothels, schools and households, people are talking about sex. Periodic interviews conducted at strategic sites throughout the city are yielding a wealth of information about sexual behavior for HIV/AIDS prevention program managers and evaluators. These interviews are part of the behavioral surveillance survey (BSS) developed by the AIDS Control and Prevention (AIDSCAP) Project.

Modeled after the serological surveillance used in many countries to detect the emergence of HIV and monitor epidemic trends, the BSS involves administering structured questionnaires to sample groups of target populations in specific geographic areas. The survey is designed to collect detailed information about the sexual behaviors that increase or reduce people's risk of HIV infection and provide indicators that can be tracked over time.

In Bangkok, the BSS is part of the Bangkok Fights AIDS (BFA) Project funded in part by AIDSCAP and coordinated through the Bangkok Metropolitan Administration (BMA). Interviews with more than 3,000 people are conducted every six months among the six groups targeted by the program.

A typical interview in Bangkok lasts no longer than 30 minutes. Interviewers found that it took about 15 minutes to build sufficient trust and rapport for respondents to reveal intimate information about their sex lives. After conducting initial qualitative research, the project team decided to have women respondents write the answers to more sensitive questions on a self-administered questionnaire.

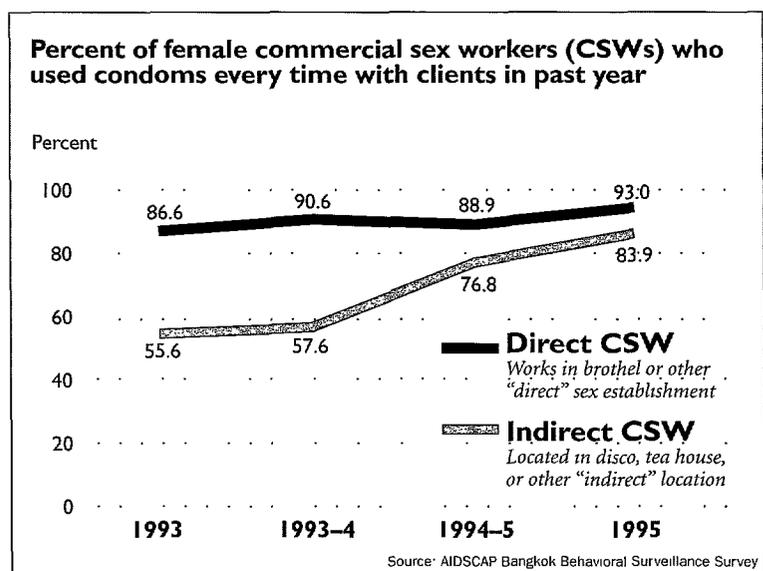
Like epidemiological surveillance, BSS can serve as an early warning system, alerting policy makers and program managers to increases in risk behavior. It can also help guide prevention programs by identifying groups whose behavior makes them particularly vulnerable to HIV infection and specific behaviors that need to be changed. In Bangkok, for example, data from the BSS convinced project managers of the need to direct prevention interventions to single, sexually active women who are not commercial sex workers.

For evaluation, BSS provides a baseline for measuring the impact of prevention efforts and a series of cross-sectional "snapshots" of behavioral trends among vulnerable groups. This kind of "big picture" is more useful to policy makers and program managers than the results of small KABP (knowledge, attitudes, beliefs and practices)

studies, noted Stephen Mills, evaluation officer and epidemiologist in AIDSCAP's Asia Regional Office in Bangkok.

Even though AIDSCAP's Thailand program will end in September 1996, the BSS will continue to help guide and evaluate HIV/AIDS prevention in Bangkok. At the request of the BMA, AIDSCAP's regional office recently held a workshop on behavioral surveillance for BMA staff.

The success of BSS in Bangkok has generated interest throughout Thailand and in other countries. The Thai Ministry of Health has begun behavioral surveillance modeled after the BSS in most of the country's provinces. AIDSCAP is starting the first round of behavioral surveys



Data on trends in consistent condom use among two groups of sex workers in Bangkok alerted program managers of the need to strengthen prevention interventions targeting "indirect" sex workers.

for the HIV/AIDS Prevention Project (HAPP) in Indonesia and is providing technical assistance in behavioral surveillance to the AIDS Prevention and Control (APAC) Project in Tamil Nadu, India. In Africa, AIDSCAP is applying the BSS methodology in Senegal.

Why all this interest in behavioral surveillance? Mills believes the BSS fills two gaps in evaluation information: what is the short-term effect of prevention interventions and what are the trends in risk behaviors among vulnerable groups? "Even though we can't pick apart the impact of different interventions, we are interested in whether the combined interventions are working together to change risk behaviors," he added. "In Bangkok, we can say that behaviors are changing."

—Kathleen Henry

During the recent evaluation of AIDSCAP's program in Haiti, this emphasis on intermediate indicators proved a useful way to detect progress toward behavior change among populations with high knowledge of HIV/AIDS and increasing but low rates of condom use. Evaluators found that indicators such as the ability to discuss HIV/AIDS with sexual partners and the ability to discuss condom use may be good predictors of behavior change.

In addition to shedding light on progress in encouraging people to change their behavior, careful examination of intermediate indicators provides valuable information for future HIV/AIDS prevention efforts. For example, the Haiti results suggest that those who have high knowledge of HIV/AIDS and confidence in their ability to negotiate condom use but are still not using condoms do not perceive themselves to be at risk.

"The intermediate indicators allow you to see where the obstacles are," Amon said. "And that's important because you need to be able to adapt your messages to those subsets of the population who haven't responded to your message yet."

One of the most promising ways to monitor and assess progress toward behavior change, according to Dr. Tarantola, is the behavioral surveillance survey AIDSCAP has conducted in Bangkok. These periodic surveys of sample groups of populations targeted by the HIV/AIDS prevention program in Thailand have yielded useful insights for improving interventions and tracking trends in high-risk sexual behavior (see page 33.)

The AVERT Model

Another tool to help program managers and evaluators understand the impact of a variety of influences without conducting studies to measure HIV incidence is the AVERT

model developed by AIDSCAP. This mathematical model uses information on HIV and STD prevalence and on behaviors such as condom use and numbers of sexual partners among pairs of target populations— young women and older men, for example, or sex workers and their clients—to estimate the number of HIV infections that could be averted through interventions and the resulting changes in behavior or STD rates.

For example, the model shows that increasing consistent condom use from 10 to 42 percent among men and their sex worker partners in an area where HIV prevalence is 5 percent for men and 15 percent for sex workers would reduce the number of HIV infections that could be expected to occur in a year by 33 percent.

Such projections can help program managers decide where to target their interventions. They will also be helpful to HIV/AIDS advocates, Dr. Hassig points out, because they "show what it takes to stop the epidemic."

Given the complexity of HIV/AIDS evaluation, many have pointed to the need for one simple statistic—a "super-indicator" similar to family planning programs' estimates of "couple-years of protection"—to demonstrate to policy makers, donors, program managers and field staff that HIV/AIDS prevention works. The estimates produced by AVERT are a possible candidate for such an indicator. However, because of the diversity of HIV/AIDS prevention programs, a single indicator that could serve as a common measure for all programs may not be feasible.

Building Capacity

Assessing efforts to build the capacity of local organizations to sustain long-term prevention interventions is one of the most important—and challenging—tasks facing AIDSCAP

evaluators. "Capacity building means many things to many people," said Kathi Kotellos, AIDSCAP associate evaluation officer. "It's difficult to define and therefore difficult to evaluate."

AIDSCAP looks for improvements in technical, managerial and administrative skills and systems and in the ability to communicate and collaborate with other organizations. The project uses qualitative and quantitative methods to monitor and evaluate capacity building, including process data collection, in-depth interviews with AIDSCAP country program managers, case studies and rapid organizational assessments.

With all of these methods, AIDSCAP collaborates with its implementing organizations to assess progress. "We want to find out—from the organization's perspective—what has changed," Kotellos explained.

Many of these organizations are interested in strengthening their evaluation capacity. By involving implementing organizations in every stage of the process, beginning with project design, AIDSCAP works with them to enhance their skills and promote a better understanding of the value of evaluation.

"Evaluation is often used as a sword over someone's or some project's head," Dr. Hassig said. "We've tried to emphasize a learning perspective and to create ownership, so people in the field aren't afraid of the evaluation process because they're part of it."

Designing and implementing AIDSCAP's evaluation plan has also been a learning experience for AIDSCAP's evaluation staff, according to Dr. Hassig. "I think we've demonstrated that evaluation is an extremely complex process that should be approached with respect and used where it is probably most instructive—to make programs better."

Partnerships for HIV/AIDS Prevention

Promoting Collaboration in Ethiopia and Tanzania

by Emily Nwankwo and Alemayehu Takele

Experiments in fostering collaborative relationships among organizations involved in HIV/AIDS prevention are reaping benefits in two African countries.

In most parts of the world, local community-based groups have been the first to respond to HIV/AIDS. From AIDS service organizations formed by those directly affected by the epidemic to community groups to established health and development organizations, nongovernmental organizations (NGOs) have been at the forefront of HIV/AIDS prevention and care efforts.

Many believe that the key to sustaining prevention and care efforts is giving these grassroots organizations the resources and skills they need to design, manage and evaluate HIV/AIDS projects. Such capacity building is the central purpose of the programs carried out by the AIDS Control and Prevention (AIDSCAP) Project with funding from the U.S. Agency for International Development in more than 40 countries.

AIDSCAP recognizes that capacity building involves more than training in technical skills. Many

NGOs also need help strengthening their organizational and management skills—and their ability to work together.

“When resources are scarce and the need is great, competition is natural, even among the best-intentioned people,” noted Penina Ochola, AIDSCAP’s resident advisor in Tanzania. “Our challenge is to help NGOs organize complementary efforts that make the best use of the strengths of each group.”

Communication and coordination among NGOs and between NGO personnel, representatives of other private organizations and government AIDS control staff are also essential for sustainability.

“The financial and material expenditures needed for HIV/AIDS prevention are beyond the capacity of an individual organization, and often scarce resources are wasted when organizations duplicate each



A drama about HIV/AIDS enlivens a training workshop for peer educators in Tanzania.

others’ efforts,” said Mulunesh Tenagashaw, AIDSCAP resident advisor for Ethiopia.

Examples of mechanisms to help organizations coordinate prevention resources and activities include AIDSCAP-initiated “focus site intervention teams” in Ethiopia and NGO “clusters” in Tanzania.

Forming NGO Clusters

“Clusters” is the name the Tanzania AIDS Project (TAP), which is funded by the USAID Mission in Tanzania and implemented by

AIDSCAP, has given to groups of NGOs working collectively in a region to carry out HIV/AIDS prevention and survivor support activities. More than 100 NGOs have joined TAP's network of NGO clusters in nine regions throughout Tanzania.

Each of the nine priority regions, which were identified by a National Institutional Needs Assessment in 1994, has more than 1 million people and a high HIV prevalence rate. Just over half the Tanzanian population lives in these regions.

NGOs in the nine regions were contacted in April 1994 to find out whether they were interested in participating in an HIV/AIDS preven-

Continuing dialogue and interaction are essential.

clearly to hijack all cluster powers, denying others access to funding while gaining more exposure and experience.”

A lengthy series of TAP-facilitated workshops and meetings among NGO representatives in each cluster enabled them to develop a common understanding of the HIV/AIDS situation in their regions and the individual and collective strengths and weaknesses of their organizations. During this process, some NGOs decided that the cluster concept was not for them—and opted out.

This “working through” of cluster purpose and expectations during the formation process later helped the founding members rapidly develop plans for comprehensive HIV/AIDS prevention and survivor support (see p. 42). Together they developed project goals and strategies and mapped out which target populations and technical areas each NGO would cover.

Since the vast majority of the estimated 400,000 new HIV infections in Tanzania every year are transmitted through heterosexual intercourse, each cluster project includes communication interventions to encourage people to adopt safer sexual behavior, efforts to increase condom accessibility through community-based outlets, and activities to help decision makers identify policies that support behavior change. Cluster NGO staff encourage people to seek effective treatment of sexually transmitted dis-

eases (STDs) in the clusters where treatment services have been strengthened through separate, TAP-sponsored interventions.

Support for orphans and families affected by HIV/AIDS, including home care and counseling, is an important part of each cluster's activities. Over the past 13 years, an estimated 150,000 Tanzanian children have lost one or both parents to HIV/AIDS. By the year 2000, there could be 750,000 AIDS orphans in Tanzania.

Cluster Management

In each cluster, members chose an anchor NGO with proven financial and management ability to lead them. To be eligible to be an anchor NGO, an organization must be recognized as a leader in the community, able to establish an independent bank account for the cluster, registered under the Societies Ordinance in Tanzania, and willing to claim ownership of the project and its participants. It also must have a qualified accountant.

The anchor NGO is responsible for hiring staff to manage cluster activities, dispersing funds, overseeing financial management and execution of planned activities, submitting project reports, supervising cluster activities, and holding monthly cluster meetings.

Management of each cluster is facilitated by a five- to six-person steering committee of NGO representatives, which meets as often as monthly to review progress on scheduled activities, and by a subcommittee composed of two representatives from each NGO, which meets quarterly or semiannually.

Although the anchor NGO has the primary—and contractual—responsibility for managing cluster activities, member NGOs are accountable for their own plans of action and financial expenditures. Each NGO works with its own target group and in its own areas of



A peer health educator sells condoms during a World AIDS Day event at the national stadium in Addis Ababa, Ethiopia.

tion network. They were also asked to fill out a matrix to summarize their interest and experience in different types of HIV/AIDS interventions.

“It was important to consider the age of each of the NGOs and how much experience they were to bring to the cluster operations,” Ochola explained. “Some of those who were very interested were young and inexperienced and had not yet understood the mechanisms of operating with donor funding. We also were wary of those whose interest was

expertise. For example, in the Tanga cluster the Tanga AIDS Working Group concentrates on home care and counseling while the Tanga chapter of the Society for Women Against AIDS in Africa (SWAA) specializes in peer education.

The role of TAP is to provide technical and material assistance to the clusters, facilitate meetings among representatives from different clusters, and provide training to strengthen NGO capacity in management, leadership, planning and evaluation. A TAP NGO coordinator is assigned to assist and monitor each cluster. TAP staff also provide guidance on policy issues and coordinate cluster activities with those of other institutions involved in HIV/AIDS interventions in Tanzania.

TAP has conducted training workshops for NGO staff to transfer skills in project design, training peer educators, materials development, accounting and financial management, syndromic management of STDs and condom social marketing. Follow-up training is provided through monitoring and technical assistance visits by TAP staff.

Lessons Learned

Forming the clusters—and operating them successfully—has required a great deal of time, patience, and energy. Continuing dialogue and interaction are essential: among member NGOs in each cluster, between each cluster and TAP management, and—increasingly—among different clusters.

Because phones are unreliable and electronic mail or faxes are rarely an option, the best way to communicate is simply to travel to each location, often over vast distances on roads that are in poor condition. Such time-consuming travel is a hardship for NGO personnel, who are often volunteers with other full-time jobs, but it is unavoidable.

The initial screening of NGOs was extremely important. Local NGOs are not homogeneous. They differ in experience, resources and scopes of work. While many of the NGOs considered for the clusters had a strong background in HIV/AIDS work or community development, others were opportunistic “briefcase NGOs” with no staff or relevant experience.

TAP learned the importance of clearly stating from the start the level of funding potentially available and the amount of serious work required to qualify for it. Because no specific budget figures were discussed as clusters began to form, disappointments were inevitable. Yet without some promise of funding, it would have been impossible to attract enough NGOs to form viable clusters. Many potential cluster members also had unrealistic expectations about the time they would need to contribute and the seriousness with which their efforts would be monitored.

Finally, personnel in all clusters required significantly more skills building than originally expected. Areas that required attention included: meeting planning and execution, proposal and report writing, activity and results monitoring, planning, and financial management and reporting.

Despite these difficulties, the participatory process has generated enthusiasm, responsibility and ownership of the cluster projects among the NGOs. They say they feel empowered to manage any project within their regions. Other positive results of the cluster experiment so far include less duplication of effort, less unhealthy competition for support and clients, and greater involvement and mutual support among the NGOs.

Intersectoral Teams

Another form of collaboration promoted by AIDSCAP among organizations working in HIV/AIDS prevention has also strengthened prevention and reduced duplication of efforts. Through “focus site intervention teams” (FSITs) in Ethiopia, AIDSCAP brings together not only NGO staff, but personnel from regional health and education bureaus, municipal governments, factories, religious groups and community organizations.

These intersectoral teams are part of comprehensive programs initiated by USAID and AIDSCAP in four regions where surveys have



World AIDS Day events organized jointly by FSIT members offer opportunities to mobilize Ethiopian youth to prevent HIV/AIDS.

identified a high prevalence of sexually transmitted disease: Tigray, Amhara, Oromia, and the Southern Nation's, Nationalities and People's Regional Governments.

Each of the four FSITs is coordinated by a chairman and a secretary selected by members of the team. Team members meet at least once a month to discuss progress reports, divide tasks among themselves, and plan how to mobilize local residents for action against HIV/AIDS. Member organizations carry out separate interventions, but coordinate their activities to ensure that all target

audiences in a focus site receive the information and services they need to reduce their risk of HIV infection.

In each focus site, AIDSCAP's strategy is to involve all the key actors, according to Tenagashaw. For example, factory representatives were invited to participate in the FSITs to help team members gain access to managers, whose support was needed for workplace prevention programs.

Some members were dubious when asked to join an FSIT.

"They told us, 'There are other regional committees that deal with health issues,'" Tenagashaw said. "But when we explained the purpose of the FSITs, they understood that this was something different—not a policy-level committee, but an action-oriented grassroots team that is very close to the intervention."

FSITs at Work

In the town of Mekelle in Tigray, the FSIT consists of representatives of the youth club, the women's association, the municipality, the regional labor and social affairs office, the Mekelle branch of the Family Guidance Association, the Mekelle Flour Factory, the Organization for Social Services of AIDS (OSSA), the regional education and health bureaus and the Mekelle health center, as well as two international NGOs, Population Services International (PSI) and the Mekelle branch of the Red Cross Association.

Mekelle FSIT members meet regularly to report on activities, discuss problems encountered and seek common solutions. They develop joint action plans and lend each other cars, video recorders and other equipment. They also pool their resources to organize large public gatherings such as annual World AIDS Day events.

FSIT members believe that their collaboration is one of the main reasons for the success of efforts to promote safer sexual behavior among

groups targeted by the program. Changed attitudes toward condom use are particularly noteworthy, according to one FSIT member.

"Until recently, people felt shy about carrying condoms in public," said Yirga GebreeEgziabher, OSSA representative for Tigray. "But now youngsters and adults—men as well as women—feel no qualms about carrying condoms in public. Even married couples were seen taking condoms from distributors without fear on World AIDS Day."

PSI reports that 50,000 condoms a month were sold in Mekelle in 1995. Monthly sales are averaging 60,000 in 1996, up from 20,000 in 1993.

In the southeastern town of Nazareth in the Oromia region, the FSIT promotes education about HIV/AIDS and other STDs, strengthens condom distribution, organizes seminars and meetings, and trains community health workers. Each member of the team plays an important role.

"The town council, a member of the FSIT, has been instrumental in helping the FSIT reach the people and in persuading bar and hotel owners to send commercial sex workers to us for education," said Sister Tayetch Lemma, a nurse who is the zonal STD/AIDS coordinator.

The FSIT has also organized anti-AIDS committees and carried out joint educational activities at schools and factories, she added. "The fact that members of the FSIT are working together has given strength to activities in focus sites."

One result is a steady increase in condom sales. Average monthly sales were 70,000 in 1995 and are expected to reach between 80,000 and 100,000 in 1996. PSI's agent in Nazareth estimates that 80 percent of the town's sexually active population uses condoms.

FSIT coordination has also strengthened the efforts of AIDSCAP and an NGO called

Nazareth Children's Centre and Integrated Development (NACID) to reach two important target audiences—ex-servicemen and the rural population. FSIT members providing HIV/STD education to these groups facilitate referrals to NACID and Ministry of Health clinics.

FSIT Results

Sharing resources and coordinating the activities of public and private sector organizations has enabled the FSITs to accomplish far more than would have been possible if each member organization had worked separately—at far less cost. FSIT member Dr. Degefu Girmay, STD/AIDS coordinator of the Tigray Health Bureau, believes that the organizations would have had to spend ten times as much to get the same results.

Regular meetings keep FSIT members informed about the other organizations' activities, enabling them to avoid duplicating efforts. For example, an NGO dropped its plans to create new HIV/AIDS materials for youth when its FSIT representatives learned the education bureau had already developed materials they could share. In some sites, FSITs divide up responsibilities for monitoring workplace activities.

Bringing together FSIT members has also helped build better understanding and stronger relationships between the governmental and non-governmental sectors in the four focus sites, Tenagashaw said. "The more people come together, work together and share experiences, the more they start to realize that this is an essential element of AIDS control and prevention activities."

Alemayehu Takele is a senior reporter for the Ethiopian News Agency. Emily Nwankwo is a program officer in AIDSCAP's Africa Regional Office in Nairobi, Kenya.

OPINION



Dr. Peter Lamptey

Expanding the Partnership

The Private Sector's Role in HIV/AIDS Prevention

AIDSCAP's "Businesses Managing AIDS" Project and other efforts to help owners and managers understand the potential impact of HIV/AIDS on their businesses—and the benefits of HIV/AIDS prevention—are the key to encouraging greater private sector involvement in slowing the spread of the epidemic.

Every day, another 7,500 people become infected with HIV. As the numbers of AIDS cases and lives lost continue to mount, it is easy to become discouraged. But experience shows that when sufficient resources are committed to comprehensive HIV/AIDS prevention programs, it is possible to slow the spread of the epidemic.

Among developing countries, the best example of an effective, comprehensive program is in Thailand, where the government has devoted more than \$50 million a year and considerable political capital to support HIV/AIDS prevention and care. Unfortunately, such a response is rare. Although it is possible for governments in every region to follow Thailand's example in establishing policies that encourage and support prevention, few governments in the developing world have the same level of financial resources to spend

on HIV/AIDS.

The public sector supports most HIV/AIDS prevention and care activities in developing countries. Significant funding sources include international donors, such as the U.S. Agency for International Development (USAID), the Overseas Development Authority and the European Community, and international banking institutions such as the World Bank. Local nongovernmental organizations (NGOs) and international private volunteer organizations (PVOs) implement many of the grassroots prevention and care efforts in developing countries but often require support from donor agencies.

When sufficient resources are committed to comprehensive HIV/AIDS prevention programs, it is possible to slow the spread of the epidemic.

Another sector with an important stake in the health of those at risk of HIV infection—the private commercial sector—has played a minor role in supporting HIV/AIDS prevention and care to date. The conventional wisdom is that the private sector is not interested in funding HIV/AIDS prevention and care. However, recent experience in many countries suggests this is

not necessarily true.

A number of enlightened local and multinational companies are beginning to recognize the importance of protecting their workers from HIV infection. Many of these businesses are motivated by a sense of moral obligation, but most also

view support for HIV/AIDS prevention as a cost-effective investment.

Since HIV/AIDS predominantly affects the most economically productive age groups, the epidemic will have a significant impact on private industry. AIDS morbidity leads to increased absenteeism, lower productivity and rising health expenditures for employers. AIDS mortality increases training costs for replacement employees and, in some countries, results in losses in productivity when employees attend funerals of relatives and friends. AIDSCAP studies in Kenya, Senegal, Thailand and the Dominican Republic have documented the potential impact of HIV/AIDS on local businesses. In Kenya, for example, HIV/AIDS could increase labor costs for some businesses by 16 percent by the year 2005.

HIV/AIDS programs for the workforce are one of the most important approaches to involving the private sector in HIV/AIDS prevention and care. They usually include policies to minimize discrimination in the workplace, HIV/AIDS prevention programs for employees and their families, and support and care for employees and family members living with HIV/AIDS.

This type of workforce program is a cost-effective way of reaching people in the age groups targeted by HIV/AIDS programs and of reinforcing prevention messages transmitted through other channels. The powerful influence of corporate culture can also help change social norms related to HIV/AIDS, and workplace policies can serve as models for national policy.

A number of enlightened local and multinational companies are beginning to recognize the importance of protecting their workers from HIV infection.



Marcia Erskine (standing), private sector officer of the Jamaica HIV/STD Prevention Programme, leads a workshop for employees from companies in the Montego Bay Free Zone.

Perhaps most important, workplace programs help leverage additional resources for HIV/AIDS prevention and care from the private sector. The Transport Corporation of India (TCI), for example, matches AIDSCAP's funding for a project to prevent HIV/AIDS and other sexually transmitted diseases among

transport workers and their partners in towns on the India-Nepal border (see page 10). In Tanzania, businesses and AIDSCAP share the cost of workplace prevention programs conducted by the Organization of Tanzania Trade Unions.

Helping private sector owners and managers understand the potential impact of HIV/AIDS on their workers is the key to leveraging financial support for prevention and care. "Businesses Managing AIDS," AIDSCAP's package of private sector AIDS policy (PSAP) materials that provide managers with information and guidelines for establishing HIV/AIDS prevention policies and programs in the

workplace, includes models for determining the costs and benefits of implementing or failing to implement HIV/AIDS programs. Managers who participated in field tests of PSAP workshops in several African countries said they would be willing to pay to attend such workshops in the future.

HIV/AIDS programs can also benefit from the private sector's considerable experience in commercial service delivery—particularly its expertise in management, marketing, research and financial management—and from the efficiency and quality often fostered by competition in the private market. Social marketing of condoms is an excellent example of this approach. In most countries nonprofit organizations such as Population Services International (PSI), the Futures Group and the Contraceptive Retail Sales Company work with private wholesalers and retailers to expand access to condoms. In others, social marketing programs use the distribution network of a private company. In the Dominican Republic, for example, AIDSCAP-supported NGOs sell condoms provided by USAID to a private pharmaceutical firm, Sterling Products International, for nationwide distribution.

During the past five years, con-

dom social marketing programs have dramatically increased condom availability, accessibility and use in many developing countries. In Africa, PSI programs have increased condom sales from 1 million to 150 million in eight years. In contrast, public sector condom distribution programs have made little progress. Other areas worth exploring for private sector involvement are social marketing of prepackaged therapy for selected STD syndromes and commercialization of HIV testing and counseling services.

A more traditional area of private sector involvement is research and development. This approach is primarily limited to industrialized countries because such efforts are too expensive for the private sector in most developing countries. Unfortunately, profit-motivated private sector involvement in HIV/AIDS research and development may lead to products that are neither available to nor affordable for most people in the developing world. An example is the antiviral drug AZT, which costs about U.S.\$2,000 per patient per year. New antiviral therapies may be even more expensive.

The private sector has a critical role to play in the development of AIDS vaccines, HIV and STD test kits, microbicides and other barrier methods such as male and female plastic condoms. The need to test some of these products in the developing world among large numbers of people at risk of HIV and against different strains of the virus offers opportunities to negotiate more equitable access to the fruits of such research. Governments, donor agencies and foundations should work with the companies to ensure that the prod-

ucts developed will be available to those who need them most.

A fourth type of private sector approach involves direct cash or in-kind contributions to the HIV/AIDS prevention activities of governments and NGOs. Multinational corporations, large local businesses, and private foundations and institutions currently play a limited role in funding HIV/AIDS prevention and care in developing countries. But a number of institutions are leading the way in contributing some of their profits to reduce the burden of HIV/AIDS prevention and care on the communities where their businesses are based.

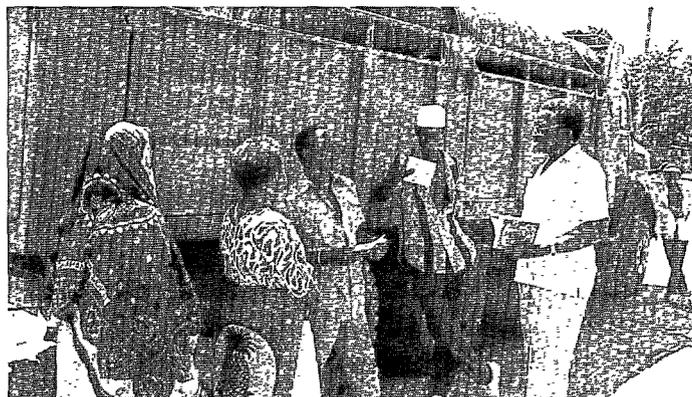
Examples of multinational companies that make significant contributions to HIV/AIDS prevention projects include DKT International, Levi Strauss and Unilever. In Brazil alone, DKT has donated nearly U.S.\$2 million worth of condoms for AIDSCAP HIV prevention activities during the past four years. A local company in Nepal, General Paper Industry, established an NGO that receives 10 percent of the company's annual export value to support development and health programs, including HIV/AIDS prevention outreach.

In-kind media contributions of broadcast time and advertising space are particularly helpful in rais-

ing awareness about HIV/AIDS and encouraging changes in social norms. In the Dominican Republic, for example, local mass media and international cable stations donated the equivalent of U.S.\$2.5 million in television, radio and newspaper exposure to an AIDSCAP mass media campaign for youth.

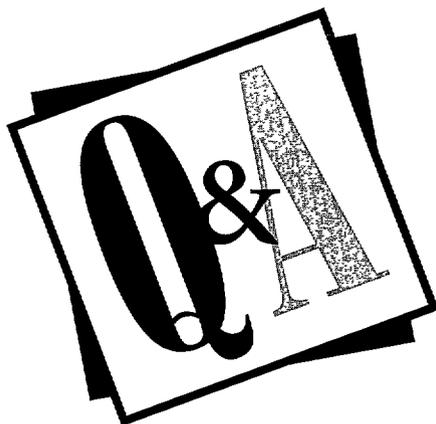
As the HIV/AIDS epidemic continues its relentless progress, it is obvious that the local public sector and donor agencies cannot provide the resources needed to undertake national-scale prevention programs or to manage and care for those with HIV/AIDS. Public sector resources for health and other development programs are already stretched thin in most countries and are unlikely to increase significantly for AIDS prevention and care. The decline in international donor support further compounds the problem. For example, funding for USAID—the largest international donor for health programs in developing countries—is expected to be reduced by about 25 to 30 percent in fiscal year 1996.

The current partnership of donor agencies, the public sector and the private noncommercial sector of NGOs and PVOs has been vital to HIV/AIDS prevention and care in developing countries. However, in order to slow the rapid spread of the epidemic and to provide care and support for those with HIV/AIDS, we need to expand this partnership to include institutions of the private commercial sector—corporations, foundations and businesses. This is one battle the developing country public sector cannot win alone.



A peer educator answers Tanzanian truckers' questions about HIV/AIDS. Some of the first workplace prevention programs were developed for transport company workers.

Peter Lamptey, MD, DrPH, is director of the AIDSCAP Project and senior vice president for AIDS programs at Family Health International.



Field Testing a Rapid Project Development Method

Tanzania and Honduras: Case Studies

The building blocks of the AIDS Control and Prevention (AIDSCAP) Project's comprehensive HIV/AIDS prevention programs in 17 countries are carefully targeted projects carried out by nongovernmental organizations (NGOs) and other local groups. Each of these 465 "subprojects" is based on a detailed document called a subagreement, which outlines the project's objectives, each organization's responsibilities in meeting those objectives, the products to be delivered by the implementing agency and the indicators for measuring whether the objectives have been met.

Because it is at the same time a proposal, a contract, a detailed implementation plan and a monitoring and evaluation guide, a subagreement is a complex document that requires contributions from program managers, local officials, researchers, financial analysts, and specialists in technical fields such as communication, STD treatment, condom logistics, and evalu-



Tanzania AIDS Project and NGO staff discuss how to integrate workplace interventions into cluster activities in Tanzania.

ation. AIDSCAP country and regional staff work closely with each implementing agency to review and strengthen every subagreement.

AIDSCAP's rapid project devel-

opment method, field tested in Tanzania and Honduras in 1995, accelerated this process by bringing together staff from implementing agencies and AIDSCAP country and

regional offices in one place. As a result, AIDSCAP and its partners were able to write, review and complete most of the subagreements for each country program in just two weeks. In both countries, representatives of the implementing agencies spent the first week receiving a one-week crash course in subproject development using a methodology called the logical framework (LogFRAME).

In Tanzania, after consultations between AIDSCAP and the NGOs, 25 NGO representatives and ten AIDSCAP staff met in Dar es Salaam and wrote proposals for nine different subprojects for the Tanzania AIDS Project (TAP), which is sponsored by the U.S. Agency for International Development (USAID) and implemented by AIDSCAP. In Honduras, representatives from 26 local public and private sector organizations first participated in a one-week training workshop on project design where they were introduced to the strategies and plan for the USAID-supported AIDSCAP program in Honduras. Ten of these organizations were invited to the second project development workshop, where they worked with six AIDSCAP staff and two consultants to complete ten subagreements.

Both programs were operating within a month of the workshops. In Honduras, the initial funds for the subprojects were presented to implementing agencies at the end of the workshop at a signing ceremony attended by the minister of health.

Below Gail Goodridge (GG), AIDSCAP's associate director for country programs, describes the rapid project development process in Tanzania and compares it to AIDSCAP's experience with subproject development in other countries. Then two participants in the project development workshop in Honduras, Juan Ramón Gradelhy Ramirez (JGR) of Comunicación y Vida (COMVIDA), an AIDS pre-

vention program sponsored by the municipality of San Pedro Sula, and María Luisa Gonzáles (MLG) of COCSIDA (Centro de Orientación y Capacitación en SIDA), an NGO based in the northern coastal town of La Ceiba, give their impressions of the process.

TANZANIA

What actually happened at the rapid project development workshop in Tanzania?

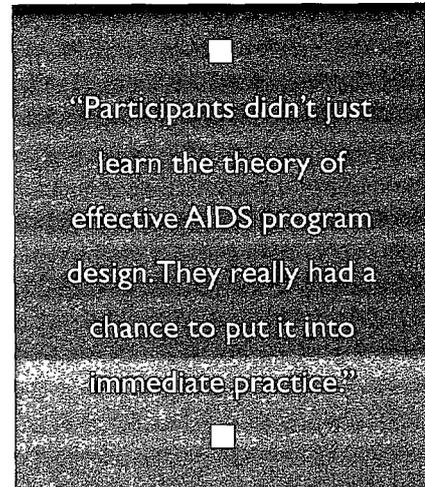
Gail Goodridge: Over a two-week period, we trained representatives from nine different NGO clusters in HIV/AIDS project design and helped them finalize comprehensive proposals. We conducted the training the first week and then in the second week, we helped each of those clusters refine their ideas based on the training they had just received.

What's a "cluster"?

GG: The strategy in Tanzania is to build cohesive teams of NGOs to work together to prevent HIV in targeted geographic areas. A cluster will typically have between nine and 12 different NGOs led by what we call an "anchor" NGO, which is responsible for program coordination and financial management of the whole cluster. This cluster strategy reduces the possibility of competition for funding among NGOs and encourages them to develop coalitions and linkages so that they work more as a team. (See page 35 for an article about the NGO clusters in Tanzania.)

So the workshop participants were from the anchor NGOs?

GG: From the anchor NGO and at least one other NGO in each cluster. But before they came to Dar es Salaam for this training exercise,



each of the clusters had done quite a bit of group planning. So the NGO representatives who came to the training were prepared to speak for the other NGOs in their cluster back home.

What was the purpose of the training?

GG: The purpose of the training was to strengthen the NGOs' design skills in a way that would lead to solid plans and subprojects.

Who were the trainers?

GG: This was a joint effort. Three trainers came from AIDSCAP's Africa Regional Office, and the TAP staff in Tanzania served as cluster facilitators. I was the one trainer from headquarters. We also had a presenter from the Ministry of Health and one from the condom social marketing team in Tanzania. The trainers, facilitators and participants all shared in the responsibility of making this work.

Michael Buja



Gail Goodridge

What did the training address?

GG: The training covered the basics of comprehensive HIV/AIDS program design and the general components of proposal development. We tried to focus on ge-

neric proposal development so in the future the NGOs would be able to develop proposals for any donor agency.

How does this process differ from the way AIDSCAP usually develops subprojects?

GG: Normally, what AIDSCAP does is work individually with representatives from each implementing organization—or in this case, cluster—to help them develop their proposals. Each proposal is reviewed at the AIDSCAP country office and put in the format of an AIDSCAP subagreement. Then the draft subagreement is sent to the AIDSCAP regional office for further review and comment. These comments are sent to the NGO for further revision.

The process was similar, but because we were all in the same place, the subagreements could be reviewed and revised much more quickly. It was a useful way of training people in subproject design and ending up after two weeks with nine strong subagreements.

How was that possible?

GG: I must say there was a lot of preparation before the two-week

training. For example, the country office staff went to every cluster and conducted what's called a "SWOT" assessment—strengths, weaknesses, opportunities and threats—and got the clusters to do a lot of preliminary thinking about what they wanted to do. So the cluster representatives came to the training with an understanding of the strengths and weaknesses of the various partners in their cluster. Some of the clusters even brought draft proposals.

What was the experience like?

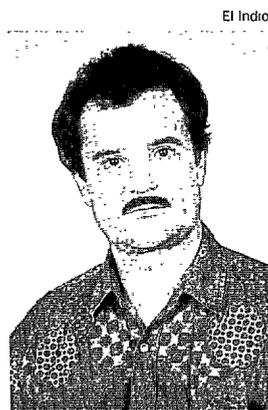
GG: It was very exciting. Each day we'd discuss an area of proposal development and then the groups would go home at night, work on that section and come in the next morning with a rewrite. Our classes would end at six in the evening, but the trainees often would stay for the next hour or two to consult individually with the trainers, and then they'd go back to their rooms and work. We had a tremendously motivated and very responsive group.

Is this something AIDSCAP would like to do again?

GG: Yes. In fact, we might have an opportunity to use this process in Indonesia, where AIDSCAP is helping the USAID Mission and the Ministry of Health implement a five-year HIV/AIDS prevention project.

So you consider the field test of this methodology in Tanzania a success?

GG: Yes. We thought it was very successful for a number of reasons. One is that it helped us launch the country program quickly. And it enabled us to transfer project design skills that will be useful to the implementing agencies regardless of which do-



Juan Ramón Gradelhy
Ramirez

nor they work with in the future.

Finally, and perhaps most importantly, because all the clusters were participating together, they could appreciate the fact that each subproject is part of an integrated country program. They worked with PSI [Population Services International] condom social

marketing folks, and they were linked up to the STD component of the Tanzania program. A lot of valuable team building was achieved.

What did AIDSCAP learn from this experience?

GG: I think we learned how to use a very effective team-building tool. And we maximized the benefit of the training by pairing it with practical, specific subproject design. Participants didn't just learn the theory of effective AIDS program design. They really had a chance to put it into immediate practice.

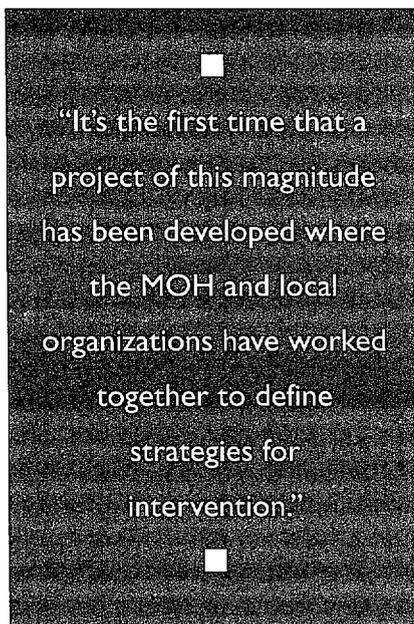
HONDURAS

What was the project development process like?

María Luisa González: It was a tough job, and time was our worst enemy. It was everyone's wish to design the best possible project based on our particular organization's strengths. We managed to formulate projects in a short time with good results.

How was the rapid project development process different from your previous experience in project development?

MLG: What made it unique was 1) the time allowed to develop the project; 2) the degree of interaction with the technical team from



AIDSCAP's regional office and office in Honduras; 3) the exchange of experiences among implementing agencies in the design of strategies; and 4) the strengthening of the ties and coordination between NGOs and the Ministry of Health (MOH).

It's the first time that a project of this magnitude has been developed where the MOH, through four priority health regions, and local organizations have worked together to define strategies for intervention. The MOH actions to improve STD services, including diagnosis and treatment, will complement the prevention projects which are being implemented by the NGOs and public sector agencies.

Juan Ramón Gradelhy Ramirez: In my previous experience, there was always an uncertainty about when projects would be approved. In the process with AIDSCAP, the developers of the projects knew that if it was a good project, it would be approved at the end of the workshop.

What made it possible to accomplish so much in such a short time?

MLG: The high level of commitment and motivation of each implementing agency to work with the beneficiary population (in our case sex workers and their clients) to reduce HIV/AIDS. In addition, the technical team from AIDSCAP was prepared for the process.

JGR: The cohesion of the participants enabled us to help each other and created a solidarity that is still present.

What types of problems did you face and how did you overcome them?

MLG: The problems were technical. It was the first time we had worked with the LogFRAME. Also, our lack

of knowledge about the computers made our work very tedious. But this was overcome, and now we have an experienced computer user working on the project.

JGR: The problems we faced were external. Due to our responsibilities and commitments to our own organizations, we were not able to concentrate 100 percent. Also, some participants' lack of knowledge about methodologies caused delays, but this was solved with help from the participants and from the AIDSCAP team.

What are the strengths and weaknesses of the process? How could it be improved?

JGR: Perhaps there was lack of unity about the criteria for subagreement content between local facilitators and the regional office, but this is understandable given that the AIDSCAP office in Honduras had just been created.

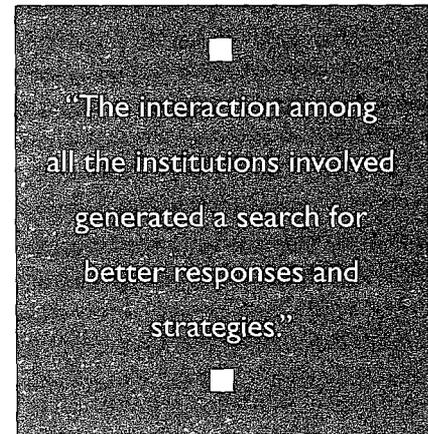
Among the strengths was a facilitating team with high expectations and dedicated to the work, a group of participants anxious to learn and do the best for their own institutions, and a blending of ideas and experiences among the whole group.

What suggestions would you have for improving this process in the future?

JGR: After the introductory workshop and selection of institutions, more time should be allowed to gather baseline information. There was only two weeks between the project development workshop and the first workshop, where AIDSCAP regional office staff presented the strategy for AIDSCAP's program in Honduras and introduced the LogFRAME and subagreement format.



María Luisa González



What did you learn from the process? What do you think your AIDSCAP counterparts learned?

JGR: We learned how to use a methodology to develop projects that is clear and precise from the development phase through implementation, monitoring and evaluation. Also, the exchange of ideas within the group enabled me to learn about the evolution and direction of prevention activities in my country because all the principal actors in the fight against AIDS were present.

This process enabled the host agency to learn firsthand the strengths and weaknesses of each institution through its representatives and proposals.

What lessons does the experience offer for other program planners?

JGR: The interaction among all the institutions involved generated a search for better responses and strategies for the projects' interventions. All of those involved in this common effort shared experiences and helped each other.

An important lesson learned from this experience is the enormous importance of coordination between the MOH, NGOs and other institutions working in the control of HIV/AIDS. Only this effective coordination and complementary actions by the institutions can have an impact on diminishing the incidence of HIV/AIDS.

WOMEN'S FORUM

Female Condom Study Explores Role of Peer Support in Sustaining Use

by Jemimah Mwakisha

A unique study explores the role of peer support in encouraging and sustaining female condom use and promoting better communication between women and men.

Ten women sat in a Nairobi office discussing something found in few Kenyan bedrooms—the female condom. They laughed about its size and shape, about their partners' first reaction to it, and about the changes it had brought to their relationships. But amid the laughter one could hear concern—and confidence.

"When I took it home for the first time, my husband quarreled with me, saying he would never eat a sweet with its wrapping on," Grace Nduta said.

As the others laughed, she explained that she had convinced her husband to try the device by telling him about the side effects she experienced with the coil and the pill. "He soon listened because he did not want any more children," she added. Now Nduta and her husband enjoy using the female condom.

Salome Kago said she didn't dare try the device with her boyfriend until the others in the group said

their partners had agreed to it.

Most of the women said that using the female condom had given them courage to discuss sex with their husbands and boyfriends. But they are still wary about saying no to their partners when they don't feel like making love.

"I would not dare because he will be suspicious that I have been with another man," Nduta said.

"I think you have to say no in a nice way, otherwise he will always misuse you," advised a third woman, Grace Buhila.

These women were participants in a study of use of female condoms sponsored by the AIDS Control and Prevention (AIDSCAP) Project's Women's Initiative with support from the U.S. Agency for International Development (USAID) Mission in Kenya. Their conversation was the result of a unique study design that allows participants to help

each other devise strategies for negotiating use of the female condom with their partners.

Unlike acceptability studies that have focused largely on the device itself, the AIDSCAP female condom study will identify reasons for continued use and non-use of the device. But the research is also designed to examine how the female condom affects women's ability to negotiate safer sex and to help them initiate and sustain use of the device through peer support.

Dr. E. Maxine Ankrah, associate director for AIDSCAP's Women's Initiative, incorporated group discussions into the study design because she was convinced that women work and think communally and that together they would



Nancy Gikaara, one of the study facilitators, displays a female condom while facilitator Anabel Kijua looks on.

come up with their own protective strategies against HIV/AIDS.

"I thought women would be more likely to use this controversial device, the female condom, if they enjoyed the support of other women," she explained.

Innovative Design

Almost half of the 7,500 people who become infected with HIV infections every day are women. Because many women's economic and social dependence on men makes it difficult for them to negotiate safer sex with their partners, the lack of an effective, affordable female-controlled method of HIV protection is one reason for the increasingly rapid spread of the virus among women.

The female condom, which has proved an effective barrier against HIV and other STDs in laboratory studies and offered 97 percent protection against the STD trichomoniasis to those who used it correctly in a clinical trial,¹ is one method that can be controlled by women, albeit with the consent of a male partner. So far, however, its availability in the developing world has been limited by concerns about its acceptability and cost. Female condoms sell for about \$2.50 each in the United States, but are available for 65 to 90 U.S. cents each to public sector organizations that distribute large quantities. In Kenya, female condoms are not available on the open market.

The AIDSCAP study, conducted at sites in Nairobi, Kenya, and São Paulo, Brazil, examined the influence of various social, cultural and economic factors on acceptability and the degree to which women feel use of a female-controlled method increases their power within a relationship. In Kenya, AIDSCAP worked with the principal investigators, USAID,

the National AIDS/STD Control Programme (NASCO) and a local advisory committee that included the deputy director of the NASCO to develop a study protocol that expanded the scope of traditional acceptability studies.

Most acceptability studies of contraceptive methods look at couples' reactions to a new method. AIDSCAP's study recruited women, not couples. "The idea was to let the woman decide who the partner is and how she can negotiate," Dr. Ankrah said.

Peer support was built into the design by enabling women to meet in small groups to discuss their experiences during the four-month study.

"Through these processes, we have been trying to see whether women's support systems—the women's groups which have assisted them in the past—could become a vehicle for sustaining their protection from HIV and STD," said Dr. Wanjiku Kabira of the University of Nairobi, a gender training specialist and one of the study's principal investigators.

Women's Networks

Another innovative feature of the study was the recruitment, which was conducted through local women's organizations in both countries. In Kenya, the investigators met with 318 members of 21 organizations to explain the purpose of the study. At each meeting, co-principal investigator Dr. Joseph

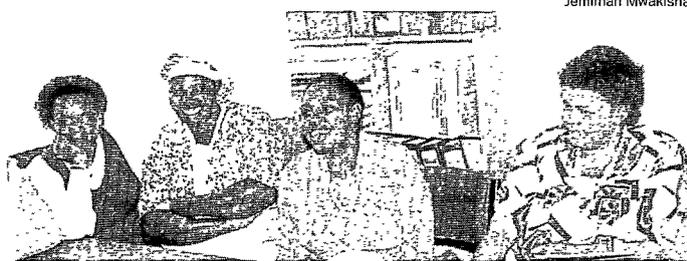
Ruminjo, an obstetrician-gynecologist, demonstrated how to use the female condom with an anatomical model. The women were given female condoms to try at home and asked to return for a second meeting if they were interested in participating in the study.

Most of the women were eager to learn more about the study once they heard that the female condom could protect against HIV/AIDS, according to Dr. Kabira. "Many have seen their neighbors, relatives or family members die of AIDS, and as we discussed it with them, we realized that the fear they harbored regarding the disease was immense."

One hundred forty-five women returned. Some women who did not meet the eligibility requirements because they were older than 40 or were widowed and not sexually active brought their younger sisters or daughters to participate.

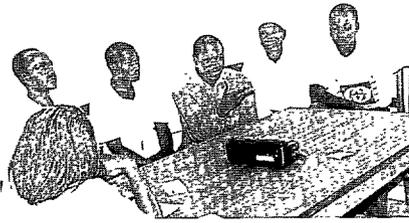
The study protocol for both Kenya and Brazil call for a total of 96 participants, representing two age groups (18 to 25 and 26 to 40) and two socioeconomic levels (upper and lower, defined by possession of such household items as refrigerators and televisions as well as education, employment and income). The most difficult women to recruit were the younger, upper-income women who were pursuing individual careers and were not as likely to participate in women's groups. However, these women were still more accessible through women's organizations than workplaces or schools, according to Dr. Ankrah.

Each of the 96 participants was interviewed individually at the beginning and end of the study. In addition, the women who came to the second meeting but decided not to enroll in the study were interviewed to find out why they had declined to



Principal investigator Kabira, right, with study participants during a focus group discussion.

Jemmah Mwakisha



Study participants' partners provide a male perspective on the female condom.

participate.

Participants were assigned to 10 groups of 8 to 13 women of the same age group and income level. Each group participated in a facilitated focus group discussion at the beginning and end of the four months to provide information for the study. In addition, each group met twice during the four months for unstructured peer discussions.

In their groups, the women discussed the female condom, the cultural inhibitions that affect their negotiation of the terms of their sexual encounters, and the power relations in their homes. It was clear that all, whether divorced, single, or married, felt vulnerable to the disease, Dr. Kabira observed.

"But the discussions also showed that married women were more disadvantaged and helpless since cultural inhibitions had more bearing on them," she added.

Men's Perspective

To get the male perspective on the female condom, the investigators asked the women to invite their partners to participate in a focus group discussion. A total of 55 male partners participated in six focus group discussions after the women had concluded their exit interviews.

At an April 24 focus group discussion in Nairobi, six men discussed their sexual lives, their wives and their girlfriends with ease. For the most part, they spoke approvingly of the female condom.

"You know, most men will always have another woman, so this device

will help a great deal in not just protecting our wives but ourselves," Wilson Amazimbi said.

Richard Maina thought the condom looked strange when he first saw it, but found it very comfortable when he tried it with his wife. "The male condom is tight and uncomfortable, but with this one, one does not feel like there is a barrier," he said. "Moreover, it is the woman who will wear it, and I do not have to wear it or handle it after."

Another man who has two wives and 11 children made the others laugh when he said he wished he had known about the female condom earlier.

However, the men who were in-



A unique study design

allows participants to help

each other devise

strategies for negotiating

use of the female condom

with their partners.



roduced to the condom by their wives could not help feeling suspicious. "We are used to using condoms with commercial sex workers, so I wondered what my wife was up to when she introduced it to me," one man said.

Another man noted that a friend almost beat his wife when she asked him to use it because he thought she wanted to use it with other men too. However, this response was unusual: only one of the 96 women reported that a partner had reacted violently when she suggested using a female condom.

That the men wanted more female condoms was indisputable. "If

you maintain the supply, we are sure to be protected and to plan our families," the father of 11 said.

Positive Process

The response to the study among both women and men was far better than the investigators had expected. Men were willing to participate in focus group discussions, and no one dropped out of the study. Some of the women decided to continue meeting in their groups after the research concluded.

Data collection was finished at the Nairobi site in March 1996. The researchers are analyzing the data and will submit a report at the end of August. Results from Kenya and Brazil will be shared with women's organizations and policy makers once they become available.

But it is already clear to the Kenyan investigators that the group discussion have had positive results. Many participants reported that they found it easier to talk to their partners about sex—something that rarely happens in most relationships, Dr. Kabira observed.

"The fact that a woman can wear a condom may be against tradition," she said, "but it provides an opportunity for the partners to talk about sex and their sexual lives."

The value the study placed on participation and contributions seemed to give the women more confidence, Dr. Kabira added. "Traditionally women are considered recipients of information and not disseminators. But in this case, they are the participants and disseminators and they own the process and contribute to it."

Reference

1. Soper, D.E., D. Shoupe, G.A. Dhangold, et al. 1993. Prevention of vaginal trichomoniasis by compliant use of the female condom. *Sexually Transmitted Diseases* 20:136-139.

Jemimah Mwakisha is a journalist with Nation Newspapers Limited in Nairobi, Kenya.

Policy Profile

by Bill Rau

Influencing HIV/AIDS Policy in Kenya: NGOs Build Consensus

Participatory, strategic policy development processes and concerted efforts to build the capacity of NGOs to influence HIV/AIDS policy are beginning to yield tangible results in Kenya.



Participants at a policy development workshop organized by the Kenya AIDS NGO Consortium in Nyeri, Kenya.

In early 1994, when a senior official in the Kenya Ministry of Health voiced hope for greater public debate on HIV/AIDS policy issues, he held only limited expectations that such discussion would occur. Despite widespread public awareness about the epidemic, most policy makers in government and other sectors chose not to consider policy responses that could help control the epidemic and moderate its impact on society and the economy.

Two and a half years later, however, the HIV/AIDS policy situation in Kenya has changed in many ways. Now the same official says he is hopeful that practical policies will be adopted and implemented as a result of the policy development processes that have occurred. For example, the government is preparing a national HIV/AIDS policy and has sought input from a broad range of technical, legal, ethical and policy

opinion makers. With support from AIDSCAP, MAP International facilitated policy-oriented discussions among church leaders, while the Kenya AIDS NGOs Consortium solicited the experiences and views of local constituents during a series of district and provincial policy workshops. The results of these and other

National leaders are

more willing to discuss

HIV/AIDS than in

years past.

efforts to shape HIV/AIDS policy include improvements in the policy climate in Kenya, better mechanisms for strengthening HIV/AIDS pre-

vention and care, and some specific changes in policy.

Policy Development

In response to the expressed need of Kenyans for greater debate on HIV/AIDS policy issues, AIDSCAP provided support to two nongovernmental organizations (NGOs), the Kenya AIDS NGOs Consortium and MAP International. Their approach was similar: to influence national policies through a process of collecting issues identified by field-based workers, program managers and civil servants and refining the issues for presentation to policy makers. AIDSCAP provided technical assistance on the policy development process, but avoided involvement in policy formulation.

Through a series of skill-building and problem-identification workshops, representatives from district-based NGOs, government and religious groups prioritized HIV/AIDS

issues they face regularly. Their problems and concerns were expressed as issues, making them more adaptable to policy responses. For example, a concern about individual rights to privacy of the results of HIV tests was expressed as a policy issue that included options for shared confidentiality.

Results of the local workshops were discussed at national workshops. Participants in the MAP-sponsored national workshop in February 1996 included leaders of Kenya's major Christian denominations and religious umbrella organizations. Research results were presented showing a high level of sexuality among religious youth, the desire of these young people for more sex education, and field-level clergy and laity support for stronger de-



The government is

preparing a national

HIV/AIDS policy and has

sought input from a broad

range of technical, legal,

ethical and policy

opinion makers.



nominational leadership on HIV/AIDS. Church leaders responded with a commitment—subsequently published in one of Kenya's daily newspapers—to formulate policies within their religious groups on 14 issues identified by participants.

The process followed by the Kenya AIDS NGOs Consortium was designed to develop consensus on priority HIV/AIDS issues among diverse groups. Drawing upon the lists of priority issues developed at

the provincial workshops, participants at a national workshop selected seven issues that consortium staff will develop into policy recommendations. The recommendations will be directed toward appropriate national authorities or shared with partners (such as a business association) better placed to pursue them in the policy arena.

The Kenyan government has been engaged in a two-year process of soliciting expert opinion, drafting and re-drafting, and consensus building to produce a national policy. In 1996, a comprehensive policy will be made public that addresses legal and ethical, social and cultural, economic and service delivery dimensions of the HIV/AIDS epidemic.

The Policy Climate

During the early 1990s, HIV/AIDS issues primarily concerned health authorities. In the years that followed, however, large segments of the Kenyan population became informed and actively involved in what are essentially policy issues. For example, politicians, religious leaders, and the media have pointed out that various traditional cultural practices (such as the sexual "cleansing" of widows) may contribute to HIV transmission and have urged adaptation of such practices to reduce risk.

National leaders are more willing to discuss HIV/AIDS than in years past. Part of the reason is that HIV/AIDS is now seen as a development issue. An entire chapter of the 1994-96 Kenya national development plan was devoted to HIV/AIDS and its impact on social well-being and economic growth. In a country where AIDS was rarely mentioned in pub-



Participants in the Organization of African Instituted Churches Bishop's Workshop on HIV/AIDS, facilitated by Map International, in Kisumu, Kenya, in May 1996.

lic discourse a few years ago, it is common to hear political leaders refer to the socioeconomic impact of HIV/AIDS and to cite specific examples of such impact on their constituents.

To back up its policy development, the Kenyan government has committed substantial resources to HIV/AIDS prevention. A loan from the World Bank is being used to expand prevention interventions and improve STD treatment and care services.

Another indication of changes in the policy climate is the growing confidence and willingness of people at all levels to speak out on critical HIV/AIDS issues. A prime example is the recent challenge to Pearl Omega, a locally developed drug initially said to cure AIDS. Legal, scientific and HIV/AIDS program specialists immediately questioned the claim and called for stronger regulatory oversight to prevent such claims in the future. The specialist and HIV/AIDS prevention communities' response to the initial reports was much faster and more public than in years past, when unsubstantiated claims for AIDS "cures" were rarely publicly challenged.

Improved Mechanisms

The means to formulate policy questions and to influence the direction

■

Policy changes can be

shaped by well-planned

strategies to engage people

at all levels in issue

identification and

advocacy.

■

of debate on HIV/AIDS issues in Kenya has been strengthened in recent years. Existing networks have become stronger and new coalitions have emerged.

The Kenya AIDS NGOs Consortium, for example, grew from about 20 members in the early 1990s to over 200 in 1996. The consortium has overcome government suspicion of NGOs and is now given credit for its coordinating role, for supporting and strengthening cooperation between the government and NGOs, and for its technical contributions to prevention and care discussions and plans. The strong working relationship between the consortium and the National AIDS and STD Control Programme is evident in their regular collaboration at workshops and public meetings.

The consortium's resource center, which existed only on paper a few years ago, is now recognized as a central source for information in Nairobi. During debate on legislation to assist children orphaned by the death of parents to AIDS, members of parliament visited the center for information.

Other networks that have emerged include the Kenya Churches AIDS Network and Women Fighting AIDS in Kenya, which provides support for HIV-positive women and women vulner-

able to infection. Also, non-health organizations have begun to take on HIV/AIDS as an issue for advocacy. The churches are major examples, but the list extends to women's and development organizations and legal societies.

Policy Change
 Improvements in the policy climate and in mechanisms for strengthening HIV/AIDS prevention are beginning to have an impact on policy in Kenya. Existing national guidelines on home-based care and counseling are being reviewed and revised by the National AIDS and STD Control and Prevention Programme. A number of businesses and NGOs have adopted or are considering adoption of policies related to HIV/AIDS in the workplace, and religious denominations have made a public commitment to adopting policies to guide clergy, laity and parishioners.

Legal issues are also receiving attention. Gaps and ambiguities in Kenyan laws related to HIV/AIDS, such as the inheritance rights of

■

Religious denominations

have made a public

commitment to adopting

policies to guide

clergy, laity and

parishioners.

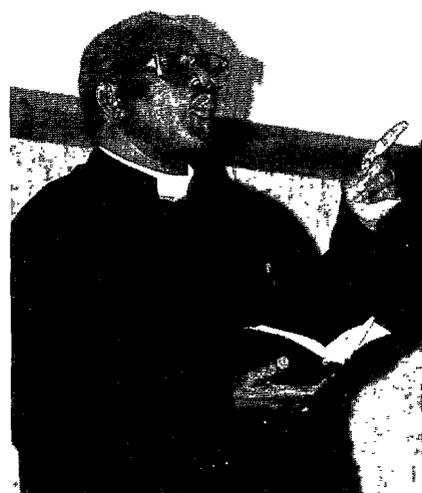
■

women, have been identified by legal experts. Legislation has been introduced and debated in parliament to provide support to destitute youth, including AIDS orphans.

While much has changed in the policy area in Kenya in recent years, many outstanding policy issues remain. Sex education for youth has been widely debated, but religious and secular groups have been unable to reach consensus on curriculum content. Radio advertising of condoms was banned in 1995, and some newspapers occasionally report statements that condoms are ineffective or lead to immorality. However, sales of condoms continue to increase. Legal precedents relating to widow inheritance, pre-employment HIV testing, confidentiality and similar issues remain to be established.

In Kenya and throughout Africa, the rapid pace at which the epidemic moves through society and the growing number of AIDS-related deaths provide impetus for policy change. As Kenya's experience demonstrates, those changes can be shaped by well-planned strategies to engage people at all levels in issue identification and advocacy.

Map International



Dr. Matthew Ajugo, chairman of the Organization of African Instituted Churches and founding bishop of the Church of Christ in Africa, speaks at an HIV/AIDS workshop in Kisumu.

Bill Rau, PhD, is AIDSCAP's associate director for policy.

Resources

Community Action on HIV: A Resource Manual for HIV Prevention and Care. Macfarlane Burnet Centre for Medical Research.

This manual assists individuals and agencies in designing and implementing projects that prevent the spread of HIV and that enable communities to respond positively to its devastating effects. It is suitable for agencies with little experience in the design and management of HIV/AIDS projects and includes a summary pack for use in the field. Copies are free (recipients must pay shipping and handling) and available from HIDNA Coordinator, c/-ACFOA, Private Bag 3, Deakin ACT 2600, Australia.

Modeling the Costs of HIV Prevention: A Resource Requirement Model for Developing Countries. World Health Organization.

This modeling approach enables users to estimate the resources needed to implement HIV/AIDS prevention strategies. Countries with severe resource constraints that need small-scale HIV/AIDS intervention programs will find this document useful. It provides a guide for evaluating current resource distribution patterns, planning resource allocation and advocating for financial support. Single copies are free (a small charge for multiple copies) from the UNAIDS Documentation Center, WHO, 1211 Geneva 27, Switzerland.

Effective Approaches for the Prevention of HIV/AIDS in Women: Report of a Meeting. World Health Organization.

This report, based on the WHO meeting entitled "Effective Approaches for the Prevention of HIV/AIDS in Women," examines the increasing threat of HIV/AIDS to adolescent girls and women and draws conclusions about the most effective approaches for preventing the spread of HIV/AIDS. Meeting participants, who convened in February 1995, focused on four themes: 1) promotion of safer sexual behavior, 2) STD care and condom promotion—experience from other fields, 3) implications for HIV/AIDS prevention and 4) future directions for policies and large-scale programs. Single copies are free (a small charge for multiple copies) from the UNAIDS Documentation Center, WHO, 1211 Geneva 27, Switzerland.

Time to Act: The Pacific Response to HIV and AIDS. United Nations.

This report seeks to increase awareness about the HIV epidemic and its potential consequences in the Pacific region and to highlight the types of action that can help contain the epidemic and ameliorate its impact. It highlights three critical aspects of the HIV epidemic: the vulnerability of Pacific societies to the spread of the HIV virus, the importance of being able to choose how to protect oneself, one's family and friends, and the central nature of the status of women. This report is a joint effort of the UN agencies in Fiji. Free copies are available (recipients must pay shipping and handling) from Mr. Somsey Norindr, Resident Representative, UNDP, Suva, Fiji.

HIV & AIDS: The Global Inter-Connection. Kumarian Press.

This book presents compelling stories about individuals and communities from Asia, Africa, Latin America, the Caribbean and the United States who are living with HIV/AIDS or are working to combat this virus. The cost is \$14.95, plus shipping and handling. Contact Kumarian Press, Inc., 14 Oakwood Avenue, West Hartford, CT 06119-2127, USA.

Preventing and Mitigating AIDS in Sub-Saharan Africa: Research and Data Priorities for the Social and Behavioral Sciences. National Research Council.

This book by the National Research Council Panel on Data and Research Priorities for Arresting AIDS in Sub-Saharan Africa, Committee on Population, details the current state of the HIV/AIDS epidemic in Africa and knowledge about the behaviors that contribute to HIV transmission. It offers recommendations on how to monitor the epidemic, collect and disseminate information on sexual behavior and HIV/AIDS, create primary HIV prevention strategies, mitigate the impact of the epidemic, and build an indigenous capacity for AIDS-related research. This publication also presents research and data priorities that could help strengthen HIV/AIDS prevention strategies. The cost of the book is \$39, plus shipping and handling. Contact National Academy Press, 2101 Constitution Avenue, NW, Box 285, Washington, DC 20055.