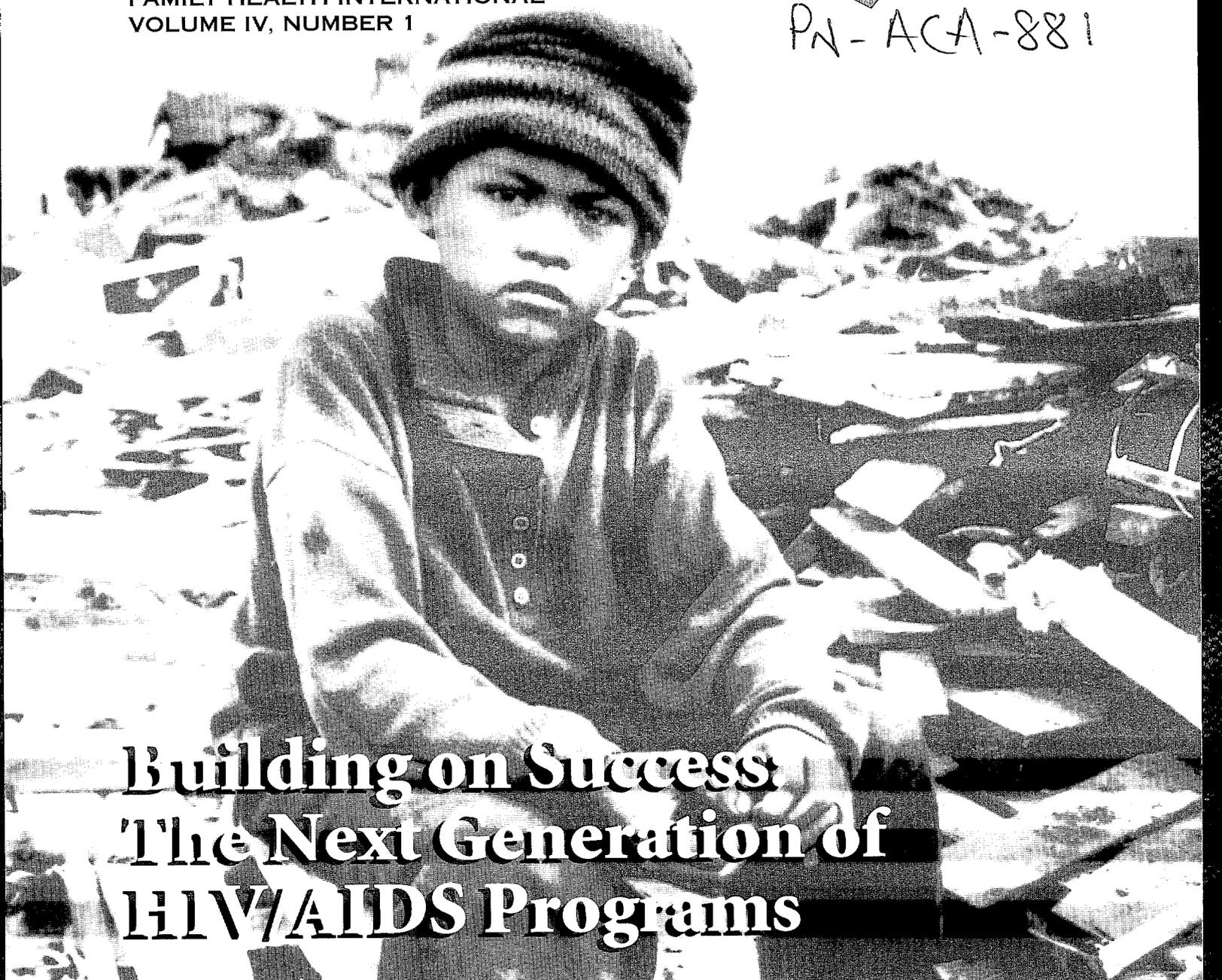


JUNE 1997

# AIDS

FAMILY HEALTH INTERNATIONAL  
VOLUME IV, NUMBER 1

PN-ACA-881



**Building on Success:  
The Next Generation of  
HIV/AIDS Programs**

**in the**

**NEWS**

**NEWS**

**NEWS**

### **Female Condom: From Research to Marketplace**

Peer support can help women who are vulnerable to HIV/AIDS and other sexually transmitted diseases negotiate the use of female condoms with reluctant partners, according to new research from six countries. This finding was among the actions announced at an international conference, "The Female Condom: From Research to Marketplace," held May 1-2, 1997, outside of Washington, D.C., and attended by more than 130 participants from 19 countries.

Studies coordinated by the AIDSCAP Project in Kenya and Brazil introduced the female condom to women through peer support groups. Group education sessions were also used in female condom studies sponsored by the Joint United Nations Programme on HIV/AIDS (UNAIDS) in Costa Rica, Indonesia, Mexico and Senegal. Support from peers during the group sessions helped women overcome obstacles to using the female condom, including unfamiliarity with the device and the need to communicate with one's partner about its use.

Conference participants also discussed ways to make the female condom more accessible and affordable to women worldwide. The device is sold widely in the United States and some European countries, but its availability in the developing world is limited to pilot projects in a few countries.

Representatives of social marketing organizations said they planned to market female condoms at subsidized prices in Zimbabwe and Tanzania. UNAIDS recently negotiated a public-sector price of about U.S.\$0.62 with the condom's manufacturer, The Female Health Company, enabling Zimbabwe and Tanzania

to buy several thousand for these campaigns. Successful pilot projects in Bolivia, Guinea, Haiti, South Africa and Zambia have demonstrated that women and men will buy female condoms at prices about twice as high as male condoms. In South Africa, for example, the Reality female condom sold for U.S. \$0.19, compared to \$0.09 for a male condom.

Conference participants noted that grassroots women's organizations in Zimbabwe had mobilized to help make the product available in that country. They recommended including the female condom in reproductive health programs to give women more options for STD protection and emphasized the need for research to monitor its introduction.

### **FHI Releases N-9 Findings**

A recent study concluded that a vaginal contraceptive film containing spermicide is safe to use but does not confer any additional protection to women from HIV and other sexually transmitted diseases (STDs) beyond the protection provided by condoms.

Conducted by Family Health International (FHI) and the Cameroon Ministry of Health with a grant from the U.S. National Institute of Allergy and Infectious Diseases (NIAID), the two-year study examined the additional protective effect of a spermicidal film containing nonoxynol-9 (N-9) among a group of 841 HIV-negative sex workers in Cameroon who volunteered to participate in the research. About half of the women used the N-9 film and half used a placebo.

Because of the paramount concern for the safety of the participants, they were counseled to use condoms every time they had sex and given regular sup-

plies of condoms. Since few women reported using the film without condoms, the study could not conclusively address whether N-9 film alone offers any protection from HIV or other STDs.

The researchers also studied the possibility that frequent use of N-9 may increase the risk of STD infections by causing sores that could enhance transmission. They found no increased risk of HIV or other STD infections from using N-9 film, although genital sores did occur slightly more often among women who used N-9.

The rate of HIV transmission was nearly the same for both groups. For 100 women using N-9 film and condoms for one year, 6.7 became infected with HIV, compared with 6.6 HIV infections using the placebo film and condoms. Rates of gonorrhea and chlamydial infection among the two groups were also similar.

"Unfortunately, the news is not good for women, since we had hoped N-9 might increase their available options for HIV protection," said Dr. Willard Cates, Jr., FHI's senior vice president for biomedical affairs. "We must accelerate research dedicated to finding new methods for women at risk of HIV and other STDs."

### **Worldwide HIV/AIDS Monitoring Network**

A network launched on World AIDS Day, December 1, 1996, will make the most up-to-date information about the HIV/AIDS pandemic available to policymakers, scientists, public health specialists and journalists worldwide. A

*continued on page 55*

AIDScaptions is published  
 three times a year by  
 Family Health International's  
 AIDS Control and Prevention (AIDSCAP)  
 Project

AIDScaptions  
 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

**Editor-in-Chief**  
 Kathleen Henry

**Senior Writer/Editors**  
 Bill Black  
 Margaret J. Dadian

**Associate Editor**  
 Arin P. Farrington

**Graphic Designer**  
 Sandy Paul

**Publication Assistants**  
 Todd Fortune  
 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



AIDScaptions 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 IV, Number 1

June 1997

*HIV/AIDS projects from Kigali to Kingston demonstrate that prevention efforts  
 can influence sexual behavior, yielding important lessons for the next genera-  
 tion of HIV/AIDS programs.*

Condom Sales Boom as Rwanda and Haiti Struggle to Rebuild .....	4
Award-Winning Mass Media Campaign Hits Home with Dominican Youth .....	10
Preventing HIV/AIDS by Promoting Life for Indonesian Street Children .....	14
Jamaicans Begin to Embrace Safer Sex .....	18
HIV/AIDS and the Church: Kenyan Religious Leaders Become Partners in Prevention .....	23
The Race to Beat AIDS on the Lao-Thai Border .....	27
Saving a Generation: Ethiopian Youth Rally to Prevent AIDS .....	32
AIDSCAP Explores Link Between HIV/AIDS Care and Prevention .....	36

**Departments**

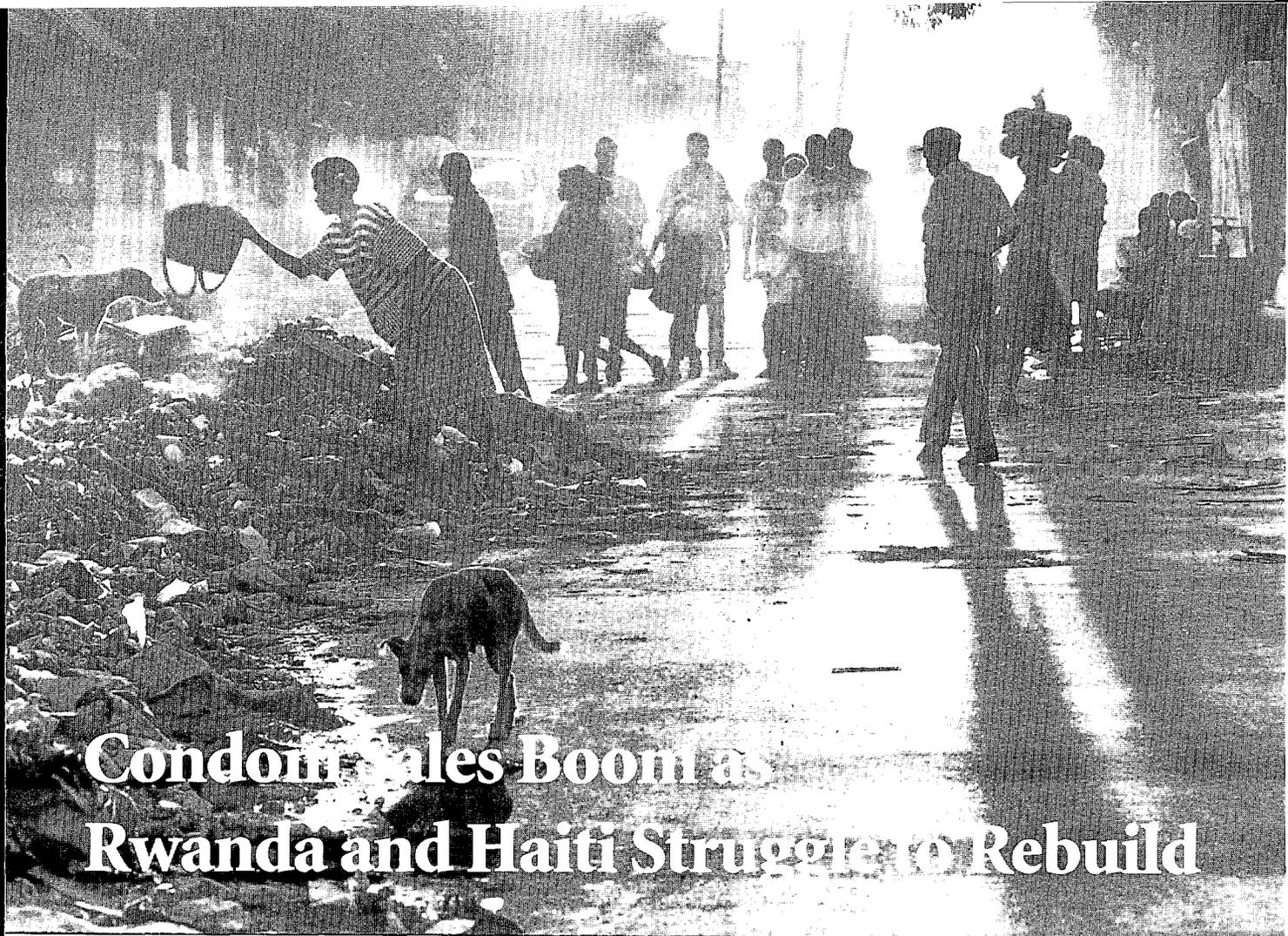
In the News .....	facing page
Opinion .....	40
<i>Integrated Reproductive Health Services:      Where Do We Go From Here?</i>	
Q&A .....	44
<i>Taking New Skills Home:      Regional HIV/AIDS Training Program Builds Capacity in Asia</i>	
Women's Forum .....	48
<i>Inclusive Prevention Efforts Fight Stigma in Rural India</i>	
Policy Profile .....	52
<i>Policy Development Initiative Reaps Unexpected Benefits in Central America</i>	
Resources .....	56

Cover Photo:

The RESCUE/AIDS HIV prevention project brings hope to Indonesian street  
 children like 12-year-old Herman, who searches Jakarta's largest dump site  
 for food and scrap to sell.

Pact

3



## Condom Sales Boom as Rwanda and Haiti Struggle to Rebuild

*A woman rummages through a trash pile on a Port-au-Prince street. Political turmoil and an international economic embargo pushed Haiti's citizens even deeper into poverty.*

Ron Hubers/Panos Pictures

*by Margaret J. Dadian*

**In Rwanda and Haiti, nations beset in recent years by bloody civil strife and high HIV infection rates, condom social marketing programs have been extremely successful despite political and economic chaos.**

In the center of Kigali's most congested traffic circle stands a kiosk. Once a newspaper stand, the modest structure was a mute witness to one of this century's bloodiest tragedies: the 1994 slaughter of more than a half million Rwandans by their fellow citizens. Less than a year later, the kiosk—freshly painted with a rainbow design—became one of the first small businesses to reopen. In the midday heat, many stop there to buy cold drinks, but also take the opportunity to ask the nurse behind the counter about AIDS and buy packets of Prudence condoms. In its new role, the kiosk has become a bright symbol of hope in a nation desperate to renew itself.

This tiny sales outlet is just one of hundreds throughout Rwanda created for condom social marketing (CSM). Using commercial marketing tech-

niques, affordable pricing and existing retail networks to promote, distribute and sell condoms, the AIDS Control and Prevention (AIDSCAP) Project's non-profit CSM programs—designed and managed by Population Services International (PSI)—have created enormous demand for these preventive devices even in places where resistance to them was once so strong they couldn't be given away.

Overcoming cultural barriers to condom use is one of the great challenges facing CSM programs around the world. Restrictive public policies, poor infrastructure and communications, disapproving religious leaders and governmental indifference also inhibit these programs in their mission to encourage behavior change and promote condom sales.

But almost nowhere has CSM been

put to the test more dramatically than in Rwanda and Haiti. These tiny nations experienced violent civil conflicts that destroyed families and communities, shut down critical government functions and ruined already fragile economies, even as both struggled to control a virulent HIV/AIDS epidemic.

With as much as 10 percent of the urban population infected with HIV, Haiti suffers from the most advanced epidemic in the Western Hemisphere. In Rwanda, the numbers are even more dire: before the war, a staggering 30 percent or more of the urban population was estimated to be HIV-infected. The social breakdown that overcame both Rwanda and Haiti threatened to drive these figures even higher, as populations were uprooted and prevention education efforts and health care delivery disrupted.

But today, Haiti and Rwanda are considered two of the world's true CSM success stories. After the AIDSCAP/PSI CSM program was launched in Haiti, for example, national monthly condom sales increased more than a hundred-fold—from an average of 3,000 to more than 400,000—even during the worst of the country's turmoil. AIDSCAP/PSI's Rwanda program, forced to close for eight months when the bloodshed began, opened 1,500 new points of sale and achieved impressive average monthly sales of more than 229,000 soon after it resumed in 1996.

That CSM in both countries triumphed over such formidable political, social, logistical and even psychological obstacles may seem astonishing, but experienced CSM programmers are not surprised. They credit the innovation, flexibility and strong community ties that are integral to CSM, as well as a fundamental drive within human soci-

ety to regenerate itself through commercial activity.

"This social and economic fact of life is an inherent advantage that social marketing programs have over other health programs that operate through the government," said Richard Frank, president of PSI.

### Cooperation Amid Chaos

After a military coup ousted Haiti's first democratically elected president, Jean-Bertrand Aristide, in September 1991, bloody civil strife became a daily reality. Demonstrations were put down with brutal force. Assassins struck in the night, leaving corpses to be found each morning in rural cane fields and on city streets by the terrorized populace. When the Organization of American States imposed an economic embargo on the country that cut off fuel and raw materials for manufacture, factories were forced to lay off workers, and businesses both small and large closed because their former customers could no longer afford to buy. Haiti—never a politically stable or economically secure country—was soon pushed even deeper into violence and desperate poverty.

At the time of the takeover, PSI had

been working with AIDSCAP for a year to expand the CSM program it began in 1989 to promote and sell the Panté condom. The terms of the embargo forced most USAID-supported projects to close or reduce their activities, but after a six-month slowdown, AIDSCAP and PSI were allowed to resume full operations as a humanitarian mission. Most government agencies, including the national health system—which had in the past provided some free condoms and information about HIV/AIDS at public health clinics—stopped functioning, and AIDSCAP, PSI and AIDSCAP's nongovernmental organization (NGO) partners became Haiti's sole source of affordable condoms and of HIV/AIDS education and behavior change campaigns.

"We suddenly found that, for better or for worse, we were essentially operating without a government to either support us, ignore us or give us a hard time," said Michele Cato, former program manager for PSI/Haiti, who now works for PSI in Guatemala.

But the military junta's political crackdown did affect important CSM activities. New restrictions on the media made it more difficult to broadcast

*People gather at the Prudence kiosk in the center of Kigali for the March 1996 launch of a new brand of socially marketed condoms, Prudence Plus.*



condom ads and HIV/AIDS prevention spots on television and radio. Condom delivery van drivers had to learn to negotiate checkpoints with armed soldiers searching for weapons and fugitives. Suspicious military patrols frequently interrogated both AIDSCAP and PSI staff about their activities.

"We had an evening training session scheduled for commercial sex workers in the town of Petit Bois," said Dr. Eddie Génécé, former resident advisor for AIDSCAP's program in Haiti. "The police broke in and insisted, despite all our protests, that the meeting was political and subversive and that we had to disperse."

But the most pressing problems confronting the Haiti program during these troubled years were logistical. For eight months during the embargo—until supplemental fuel supplies for humanitarian organizations arrived from the United States—gasoline for vans carrying condoms and educational materials to sales points around the country was extremely difficult to find. Spare

auto parts were unobtainable. The telephone system often broke down, and electricity was sometimes cut off for hours or even days, paralyzing computers and typewriters. Much of Haiti's commercial distribution system slowed to a standstill for many months, yet CSM distribution continued, even into the remote countryside, even during the worst of the shortages.

What gave the Haiti CSM program its special advantage was the central role that Haitian NGOs played in CSM sales, promotion, education and training, and distribution throughout the country. All AIDSCAP programs create partnerships with indigenous organizations and health agencies to build their country's capacity to control the epidemic, but Haiti's CSM program benefited from an unusually rich collaboration with NGOs that have years of experience in community development and health programs.

"We were all part of a very motivated network that through sheer cooperative effort was able to overcome some of the

burdens of the embargo and the unrest," said Dr. Génécé. "We shared information with each other: when one group found fuel for sale or someone discovered that a certain district or town was blockaded, we let each other know. We learned to make each gallon go a long way by shipping several months' worth of condoms at one time or splitting large shipments."

By offering NGOs training in sales and distribution and a percentage of condom revenues, AIDSCAP/PSI was able to recruit enthusiastic and often income-poor sales and delivery people with deep roots in their communities and an insider's knowledge of how to work around the dangers that seemed to come with each day. A study of Pantè sales figures from January 1992 to June 1996 found that NGOs had sold nearly 27 percent of the total; in 1994, NGO sales peaked at 43.5 percent of the total.

PSI's strong promotional campaign and the unusually high brand recognition for the PSI condom, Pantè, naturally helped support sales efforts. Points of sale throughout the country—both established commercial retail outlets and new ones created by the NGOs—increased to more than 3,000 and ultimately penetrated into all but one of Haiti's difficult-to-reach, poverty-stricken rural areas. For the first time, many of the 70 percent of Haitians who live in the countryside could find affordable condoms close to home.

"By expanding into rural areas, we were able to overcome the traditional shortcomings of commercial distribution systems, which do not extend efficiently to the poorest part of the population," said Cato.

### Devastated by Violence

The social fabric of the tiny East African country of Rwanda was ripped to shreds in a matter of hours on April 6, 1994, after a plane carrying the presidents of Rwanda and Burundi was shot down. As the news reached the Rwandan population, political and genocidal violence targeting the Tutsi minority swept through the country. Within



Newly trained condom sales agents from the Haitian NGO Association pour la Développement et Education Communautaire display their Pantè T-shirts and signs. NGO staff were responsible for more than one-quarter of the CSM program's total sales in Haiti.

weeks, hundreds of thousands of men, women and children had been murdered. When Tutsi forces regained control of the country two months later, some 2 million Hutus—fearing revenge—fled into Zaire, Tanzania and Burundi to crowded refugee camps. Within one short spring, a nation had been destroyed by ethnic hatred.

Most foreign assistance and NGO projects in Rwanda came to an immediate halt. Despite the desperate need for ongoing HIV interventions, the AIDSCAP program was also forced to close. Tragically, four PSI staff were killed in the first few days. Another survived by hiding in an attic, and a second in the sewers of Kigali; two more escaped to Burundi in a PSI vehicle.

AIDSCAP's accountant narrowly escaped death three times and lost an infant daughter to illness in a refugee camp. The stories of these staff members reflect the scale of loss that those who lived through the terror experienced.

"The survivors were still alive, but they had nothing left," said Kyle Peterson, former PSI country representative in Rwanda. "Many lost every relative, and all of their property and belongings as well."

Unable to operate within the chaos, AIDSCAP used country program funds to establish an innovative HIV and STD prevention and care program for some 2 million refugees in the Ngora District refugee camps in Tanzania. Managed by CARE International, the program was one of the first attempts anywhere to develop comprehensive prevention ac-



*A Rwandan physician practices putting a condom on a wooden model at a PSI training workshop. Prudence's traditional panther logo, seen on the condom packet and the poster on the wall, was discontinued when the CSM project found that the image seemed too violent to the survivors of a genocidal civil war.*

tivities within a refugee setting.<sup>1</sup> PSI's CSM project for the camp also broke new ground: although the Prudence condoms that refugees remembered so well from home had to be distributed free of charge, PSI nonetheless promoted them creatively and aggressively to enhance their value and thus increase their use.

When AIDSCAP and PSI finally returned to Rwanda eight months later, staff faced the difficult and sometimes disheartening ordeal of rebuilding the program from the ground up.

"When we opened the office door again for the first time, we couldn't believe our eyes," said Peterson. "All the computers and other office equipment and most of the files were gone, the windows were blown out, and the wall was full of bullet holes."

AIDSCAP/PSI's entire stock of con-

doms had disappeared from a nearby warehouse. Only one vehicle from the original office fleet remained, the one that staff had used to escape to Burundi.

But the real challenge was not the nuts and bolts of restocking condoms or reconstructing records destroyed in the looting. Returning staff perceived a profound change in the society around them, a population deeply affected by the bloody nightmare it had experienced.

"We soon realized that the physical destruction in Kigali was almost insignificant compared to the trauma the Rwandans had lived through," said Peterson. "It was the people, not the buildings, that had been destroyed."

Before the killing began, AIDSCAP/PSI had concentrated on in-

creasing the number and geographical breadth of sales points to improve condom accessibility throughout this largely rural country. By offering the incentive of earning a percentage of the sales price, PSI added dozens of new community-based sales networks and salespeople, including peer educators from CARE International in western Rwanda and Dian Fossey's Gorilla Fund in the north. An equally important focus in the early years had been a comprehensive and widespread information, education and communication (IEC) campaign to teach Rwandans about HIV/AIDS. Combined with intensive promotion of Prudence condoms as an effective means of prevention, this strategy paid off as knowledge about HIV and public understanding of the value of condoms increased dramatically.

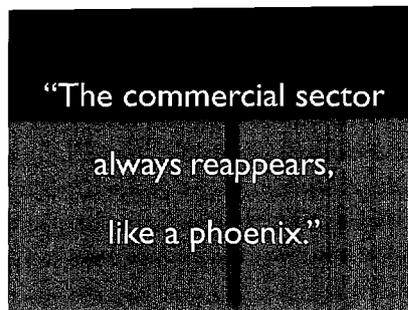
IEC and promotion remained central when the project resumed, but Kyle Peterson soon realized that the dark cloud hanging over Rwanda could overshadow beneficial messages about HIV/AIDS prevention and condom use. "The experience of the genocide so overpowered everything else that we began to doubt that any other message might be heard at all," he said.

After much discussion, Peterson and the rest of the PSI staff decided that the best way to both catch the public's attention and aid in Rwanda's long road to healing was to promote Prudence in the most positive way possible. They would use colorful, interesting advertisements and posters and create catchy, upbeat jingles for the radio that would lift spirits as they spread the Prudence brand name around the country. The new messages stressed the sweetness of life by emphasizing the benefits of taking responsibility for one's health.

"Who knows if this approach actually motivated more condom sales?" said Peterson. "But we do know that our messages stood out from the gloom."

New IEC projects also promoted prevention while quietly acknowledging the genocide, emphasizing the need to rebuild society and to protect oneself from HIV in order to live a long, happy, healthy life. A mobile video unit, first used in the Ngara District refugee camps, traveled to distant rural communities with IEC materials and videos on HIV/AIDS prevention and health. This "Ciné Mobile" has been used at military bases, in schools and at public events in almost every region of the country and as a training tool for new community salespeople. The audiences, which average 1,500 at each two-hour showing, are invited to join in a discussion afterward, which is videotaped and shown on the spot. Live, on-location interviews with government and health leaders are also fed to the site for participants to view.

Ciné Mobile's success prompted PSI/Rwanda to open its own studio in Kigali, which has since produced more than a half-dozen videos targeting at-risk



Rwandan audiences—sex workers, youth, male soldiers, adults with multiple partners—as well as those whose lives have been transformed forever by the experience of war. Many Rwandan women who were maimed or lost their families also suffered the agony of rape and the social stigma attached to their victimization. The popular "Emma Says," a short video drama set in post-genocide Rwanda, shows two women discussing how to negotiate condom use with reluctant partners. It includes a scene where one of the women, a widow, talks about safe sex with her new boyfriend, who also lost his spouse during the violence. The video seeks to empower women who survived to take control of their health while they rebuild their emotional lives.

### Riding the Phoenix

The extraordinary success of AIDSCAP/PSI's Haiti and Rwanda programs during periods of social disruption and violence reveals the value of the sturdy connections that CSM establishes with the public it serves.

In Haiti, AIDSCAP/PSI's partnerships with NGOs and other community-based organizations helped create a network for distribution, training, promotion and public education that transcended the day-to-day uncertainties of commercial distribution and fuel supply. These NGOs, whose stature in their communities is based on years of grassroots activity, provided a valuable measure of stability and helped win the public's attention and acceptance of condom use during a time when most Haitians were distracted by the turmoil around them. The Rwanda program also benefited from a community-based sales force and from its staff's knowledge of the culture and sensitivity to the blows suffered by Rwandan society.

Perhaps equally important to the success of both programs is the dedication that many CSM staff members bring to their work, as well as their ability to deal with extraordinary levels of stress and uncertainty. Creating markets in developing countries—and maintaining these markets during periods of unrest—can require nerves of steel.

"Around the world, we've learned that it takes a special kind of person to handle the stress, the frustration and the fear for one's physical safety," said Richard Frank of PSI.

Both programs built on the solid foundations they had established before disaster struck. The Pantè condom had become so well known in Haiti that recognition of the brand and the memory of its ads and jingles continued strong even when promotion activities slowed temporarily. In Rwanda, Prudence's reputation survived the war and the program's eight-month shutdown.

"As survivors slowly returned to their homes, overcome with grief and loss, we were amazed to discover how many of them remembered Prudence and recalled their high opinion of its quality before the war," said Peterson.

But most CSM programmers see a more fundamental reason for success—one they attribute to society's basic instinct for survival. In both Haiti and Rwanda, the marketplace has always been central to the culture and economy, and the commercial infrastructure never disappeared entirely in either country—even during the worst of the violence in Rwanda, even in the refugee camps of Tanzania.

"Social marketing, even during catastrophes, always make sense because the commercial sector always reappears, like a phoenix," said Peterson. "The question is, how can public health people learn to ride that phoenix?" ■

---

### Reference

1. See Benjamin JA (1996), AIDS prevention for refugees: The case of Rwandans in Tanzania, *AIDScaptions* 3(4):1-9, for a description of prevention efforts in the Ngara camps.

## Protection vs. Protectionism?

One important reason why condom social marketing (CSM) programs have been so successful in Rwanda and Haiti is that they make it possible to sell condoms at prices even low-income people can afford. In Haiti—the poorest nation in the Americas—a packet of three Pantè condoms costs only U.S.\$0.06, about the same as a packet of four Prudence condoms in Rwanda.

It's a simple equation: Less expensive condoms mean higher condom sales, more condom use and more HIV transmission averted. Fewer infections mean funding for AIDS prevention and care can be diverted to other health needs, fewer workers become sick and drop out of the economy, and fewer orphaned children become wards of the state. It's hard to exaggerate the social, economic and health benefits of making condoms affordable for all.

One critical factor that allows for such low prices in Haiti and Rwanda is the absence of taxes and tariffs on imported condoms, which make up the lion's share of socially marketed condoms. Rwanda imposes an insignificant 1 percent import tax on condoms, while Haiti does not tax imported condoms at all. Similarly, Botswana, Tanzania and Bangladesh—nations where HIV is also a major public health threat—collect no duties on foreign condoms.

Yet not all countries open their gates so readily to condom imports. Zimbabwe, for example, imposes a 10 percent import tax on condoms. Malaysia, a major condom manufacturer and exporter, protects its domestic industry by setting a stiff 25 percent duty on condoms from abroad.

Perhaps nowhere in the world are the barriers so high as in Brazil, ironically the nation with the second most advanced HIV epidemic in the Western Hemisphere. The Brazilian gov-

ernment hits condom importers with a 10 percent import duty, in addition to the steep 18 percent "circulation tax" that all condom marketers must pay up front.

"Together, these taxes represent 45 percent of the retail price of our condoms," says Carlos Ferreros, director of DKT do Brasil, which directs AIDSCAP's CSM program in Brazil. "I know of no other country that demands more from condom importers."

In fact, condom prices in Brazil are among the highest in the world. Commercial brands cost between U.S.\$0.70 and \$1.00 apiece. DKT's socially marketed condoms—heavily subsidized by international donors—sell at between U.S.\$0.25 and \$0.35. Yet even the DKT condoms are too expensive for many to buy consistently in a country where the annual per capita income is only U.S.\$3,400.

Prices on imported condoms are also affected by another regulation that requires lot-by-lot testing of all foreign condom shipments into Brazil, which Ferreros says slows distribution and adds at least a half cent to the cost of each DKT condom. In 1995, DKT became the first vendor of imported condoms in Brazil to win precertification for an offshore plant, allowing its supplier to bypass these time-consuming tests. But DKT must occasionally take government regulators to court when they refuse to honor this special status.

Ferreros believes the combination of two hefty tariffs, extensive testing and legal expenses has limited DKT's ability to market in Brazil as broadly as possible. "Without these unnecessary costs, I estimate we could have sold up to 30 percent more than we have," he says.

Lower retail prices for CSM condoms are not the only potential benefit of decreasing or eliminating tariff barriers. If prices are already set at lev-

els most people can afford, the money saved can be used to improve distribution and to boost sales by increasing promotion, advertising, and prevention education. As higher demand encourages more private sector companies to enter the market, competition increases, resulting in lower commercial prices as well.

In 1993, the Brazilian government declared a 14-month "tax holiday" for imported condoms, enabling DKT to temporarily cut prices by 10 percent. Sales increased, although Ferreros says that, given how short the hiatus was, it's hard to determine whether lower prices, better distribution or growing markets were responsible.

Ferreros and AIDSCAP/Brazil's Resident Advisor Maria Eugênia Lemos Fernandes are now working to reinstate that tax holiday permanently. They recently collected some 700 signatures on a petition calling for the elimination of the circulation tax and the import duty on foreign condoms. Supporters include influential federal and state government leaders, especially from the São Paulo region, which has been struck hard by the epidemic. The petition is now in the hands of the president, the minister of health and federal lawmakers.

Ironically, the Brazilian government's reluctance to eliminate the tariffs is at odds with its own commitment to thwarting the epidemic. In fact, Brazil is one of the few countries anywhere in the world that has passed legislation promising to pay for expensive new protease inhibitor treatments for every HIV-positive citizen who cannot afford them.

"Imagine the enormous amount of money Brazil could save by focusing on prevention," says Ferreros. "Lowering condom prices by lowering these taxes isn't just good preventive medicine—it's also real fiscal responsibility."

—Margaret J. Dadian

# Award-Winning Mass Media Campaign Hits Home with Dominican Youth

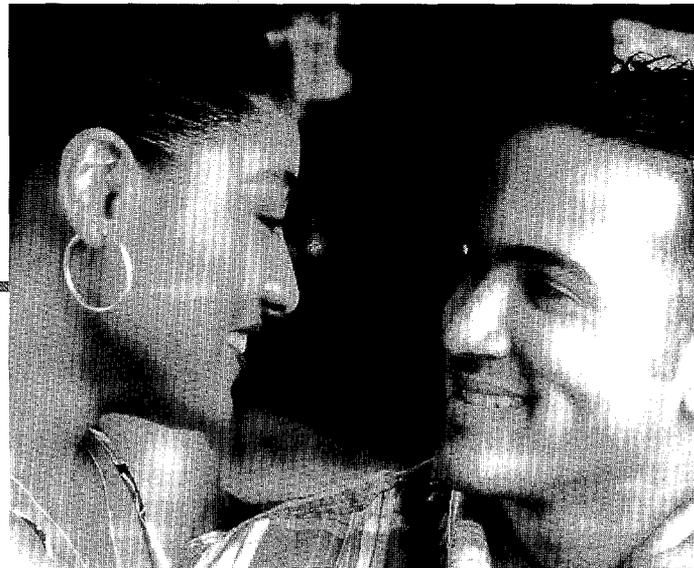
by Bill Black

It could be an ad for clothing, shampoo, musical recordings or almost any other product that appeals to adolescents. In quick succession, four attractive young couples—sometimes the same person but with a different partner—are each shown embracing on a couch in a dimly lit living room. In the background a singer croons the opening lyrics of a well-known romantic ballad, “Solamente Una Vez”: “Just one time I loved in my life, just one time and never again.”

But the mood turns starkly somber as the last of the young women looks up with a grim expression and stares directly at the camera. The word “SIDA” (AIDS) in bold red letters covers her face, and a narrator takes the sweet love song and turns its meaning on its head. “AIDS. Just one time, and never again,” he warns. “Protect yourself. Don’t change partners. Use condoms. Because just one time is enough, and never again.”

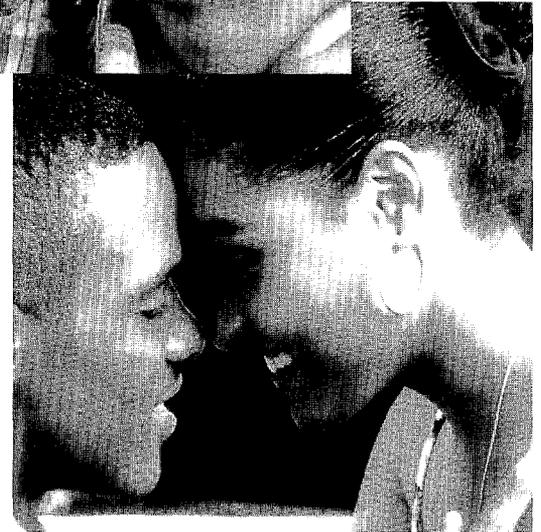
This forceful TV ad is one of four produced for a campaign by the AIDS Control and Prevention (AIDSCAP) Project in the Dominican Republic targeting adolescents and their parents. Created by a leading Dominican advertising agency, the ads used high-quality production techniques and attractive young actors to convey well-researched public health messages.

Other equally polished materials developed for the campaign—including



Cumbre

Scenes from the television advertisement “Just One Time” show a woman embracing different partners.



radio announcements, brochures, posters and roadside billboards—presented the same hard-hitting themes, designed to pierce young people’s sense of invulnerability.

As attention-grabbing and persuasive as the mass media pieces may have been, they were just part of a comprehensive, well-coordinated national campaign, explained Oscar Vigano, a communication officer in the AIDSCAP Latin America and Caribbean Regional Office. “The mass media is a tool,” said Vigano, who helped the AIDSCAP staff in the Dominican Republic create the campaign. “If you use it within an integrated plan, you can have an impact.”

## A National Strategy

The campaign grew out of research showing that large numbers of Dominicans with HIV/AIDS were between the

ages of 25 and 34 and had probably become infected during their adolescence. Studies conducted by AIDSCAP and other HIV/AIDS prevention groups also showed that many individuals knew how to protect themselves from HIV and other sexually transmitted infections (STIs), but they hadn’t moved beyond that awareness stage and changed their behavior.

After the AIDSCAP program in the Dominican Republic was launched in September 1993, one of its priorities was to work with government agencies and nongovernmental organizations (NGOs) to create communication strat-



Billboards and other printed materials reinforced the messages in the television and radio ads.

egies for HIV/AIDS prevention. As part of that effort, AIDSCAP and more than a dozen organizations involved with young people set up a special working group to develop a national plan for preventing HIV transmission among 13- to 19-year-olds. Many of those organizations have continued to provide suggestions and feedback on the mass media campaign through a special advisory committee that meets regularly.

### Interactive Advertising

In June 1995 AIDSCAP chose Cumbre, a well-known Dominican advertising agency, to produce mass media materials for the first phase of a three-part campaign that would ultimately span nearly two years.

The first TV spot created by Cumbre began airing in September 1995. In this "interactive" ad, young actors looked directly at the camera and posed questions for youthful audiences to consider, including: Are you sexually active? Do you know what STIs are? Do you know AIDS can't be cured?

The TV ad and its companion radio piece concluded with a campaign slo-

gan, "¿Sabes que si te da, no llegas?" (Do you know, if you get it, that's it, that's the end?) The first part of that question—si te da—is a word play on SIDA, the Spanish acronym for AIDS, that was further emphasized in printed materials through the use of contrasting colors.

With the "interactive" format of the first broadcast ads, the Cumbre agency intended to confront the attitudes and misconceptions revealed in research among Dominican youth. "Young people live in their own world," said Cumbre President Freddy Ginebra. "They don't have fear, they take more risks, they're adventurous and rebellious. They don't think death exists, so we looked for a 'code' to challenge them and to make them think."

The campaign's second ad, which began airing in December 1995, was also intended to raise young Dominicans' awareness of HIV/AIDS and their personal risk. Entitled "Party," it showed a crowd of attractive, well-dressed young people dancing, talking and looking for potential partners. It ended with a warning: "You can't know who to be with and who not. You can't guess who has AIDS."

Posters, bumper stickers, brochures and other printed pieces featured photos of the actors in the TV ads and reinforced the broadcast spots' key messages. These materials were distributed to government agencies, NGOs working with adolescents, radio stations, record and video stores, and movie theaters.

AIDSCAP persuaded dozens of radio and TV broadcasters and cable-TV system operators to carry those first two ads for free, as well as two more produced the following year. While some media ran the announcements only once a day, other outlets carried them more than 30 times daily. In just the first five weeks of the campaign, broadcasters contributed air time worth over U.S.\$350,000; in a year, that total reached more than \$2.6 million.

The AIDSCAP campaign received additional free exposure from news media reports. For example, *Listín 2000*, the Sunday youth magazine of the Dominican Republic's largest-circulation newspaper, carried a front-page article on the campaign and included basic information on HIV transmission and prevention.

The Dominican news media also gave wide coverage to a September 1995 rally AIDSCAP organized to announce the launch of the campaign. Some 1,000 young volunteers from NGOs working in HIV/AIDS prevention marched through the streets of Santo Domingo wearing campaign hats and T-shirts and carrying colorful balloons and banners with campaign slogans. At the launch ceremony, representatives from the government, church and other influential sectors of Dominican society endorsed the campaign.

### A Coordinated Approach

In the fall of 1995, AIDSCAP began the campaign's second phase, synchronizing the activities of many of the groups working with young people and establishing a referral network for adolescents' questions about HIV/AIDS.

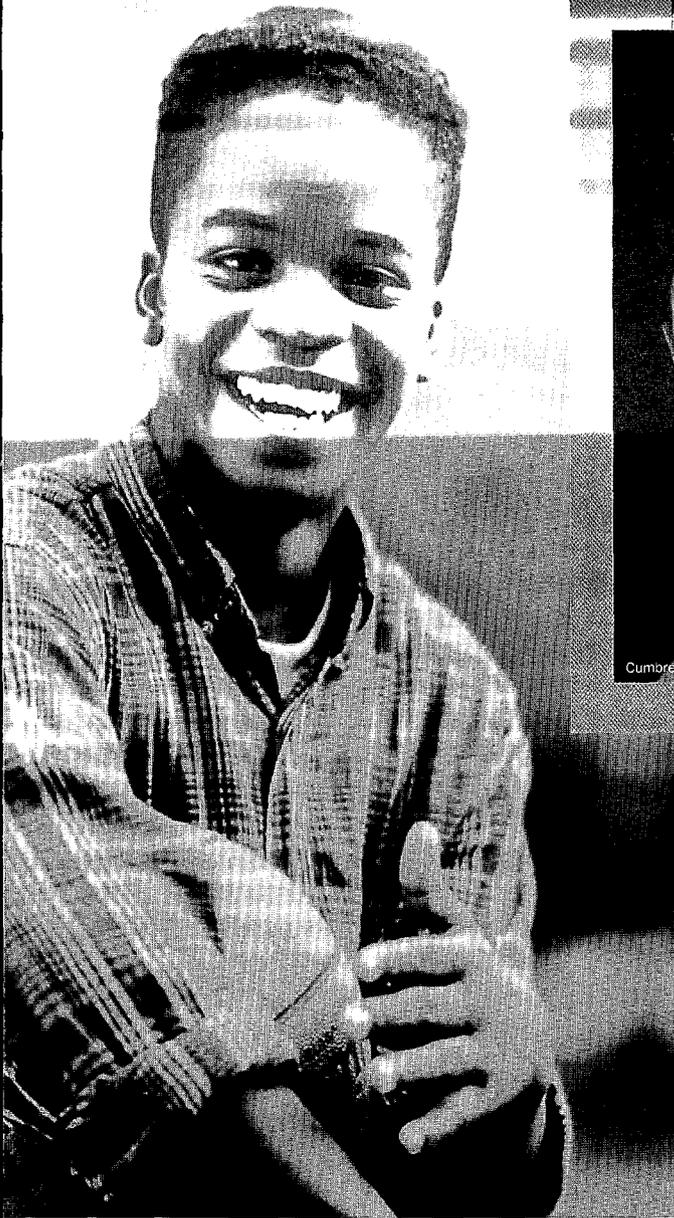
A two-day workshop brought to-

## The spots used high-quality production techniques

and attractive young actors

to convey well-researched

public information.



*These young people and the other novice actors who appeared in the television ads became so well known that members of the public and media frequently asked them questions about HIV/AIDS.*

gether representatives from government agencies, NGOs and international organizations in June 1996 to discuss what they had learned from their work with young people and suggest models for effective STI and HIV/AIDS education and counseling services. Using that information, AIDSCAP produced a manual and held training sessions for some 50 groups in four cities during the spring of 1996.

Both the manual and workshops, said Cenedya Brito, AIDSCAP's com-

munication coordinator in the Dominican Republic, "dealt with how to work with young people on any problem, not just HIV and AIDS." The materials emphasized the need to view HIV/AIDS prevention within the context of all the challenges adolescents face and the physical and emotional changes they undergo.

Collaborating with other groups on the manual and encouraging them to convey consistent messages to young people had another benefit, according

to Brito. "Working to reach a consensus," she said, "gave them a sense of participation and made them feel like 'owners' of the process. All of the groups that came together have continued participating in the campaign."

AIDSCAP also hired a research firm to conduct focus group discussions with adolescents to assess their reactions to the campaign's first phase. The majority of the participants remembered seeing or hearing the ads on television or radio at many different times of the day. When asked about the campaign's messages, the young people cited the need to protect themselves against HIV/AIDS, the need to have fewer sexual partners and the fact that HIV infection could ruin a person's future.

The focus groups also identified misconceptions about HIV/AIDS for the campaign to address, as well themes for future advertisements. Many of the participants suggested the campaign encourage better communication between adolescents and their parents about HIV, AIDS and sexuality.

As AIDSCAP and the Cumbre agency began working on the materials for the campaign's third phase, they included a step they hadn't anticipated with the first TV spots. The new actors in the third and fourth ads received "sensitization" training to prepare them for the attention they were likely to receive and "to turn them into peer educators," Brito said. The novice actors in the first two ads had become so well known that members of the public and

In just the first five weeks of the campaign, broadcasters contributed air time worth over U.S.\$350,000. In a year, that total reached more than \$2.6 million.

media frequently asked them questions about HIV/AIDS.

The third advertisement, with the "Solamente Una Vez" theme, was launched in September 1996 with another large rally affirming public support for the campaign. While the ad reinforced the campaign's message of risk awareness, it also listed a telephone hot line number audience members could call for additional information and referrals. The ad was especially effective at generating calls during the after-school hours when young people usually watch television, according to Brito.

#### Involving Parents and the Media

The last of the TV and radio ads was another interactive spot. But this one was aimed at adults, encouraging them to talk to their adolescent children. Through a series of questions, parents were challenged: Have you noticed your children are taller than you? Have you talked to them about sexually transmitted infections and AIDS? Do you realize that if you don't talk to them, you'll be responsible if they become infected? And if you haven't talked to them, what are you doing?

As with the first phase of the campaign, printed materials reinforced the radio and TV ads. Dominican broadcasters again aired the new announcements thousands of times without charge, according to data compiled by a media monitoring firm. During the last three months of 1996, the value of

the contributed air time was about U.S.\$1.6 million.

Persuading media executives to break with tradition and carry the ads for free was one of the campaign's greatest challenges, according to Brito. "I tried to convince them it's a responsibility we all have," she said. "With new stations, I also pointed to other broadcasters that were already running the advertisements. In many cases, they ended up broadcasting the advertisements more often than they promised us."

Brito, who has worked on other public health media campaigns in the Dominican Republic, believes one reason the broadcasters responded so favorably was the high quality of the advertisements. That, she said, could be an important lesson for other organizations considering a mass media campaign.

The Dominican campaign has drawn praise from other countries in Latin America. At meetings in Mexico, Venezuela, Colombia and Costa Rica, advertising and public relations colleagues gave Cumbre's Ginebra standing ovations when he showed them the ads and other campaign materials.

The television and radio spots received the top prize at another meeting in Mexico, awarded by communication experts from 20 countries who gathered in the city of Zacatecas last November for a seminar on adolescent sexual health. Along with the recognition came a grant of U.S.\$3,000, to go toward duplicating the Dominican materials and distributing them to organizations elsewhere in Latin America and the Caribbean.

*Minister of Health  
Victoriano García  
speaks at the launch of  
the mass media campaign.*

"The groups in Zacatecas," Brito reported, "were impressed with the campaign's coordination of materials and work being done by the various HIV/AIDS prevention agencies."

That careful structuring of numerous communication channels is vital to a successful campaign, as is cooperation among those who work with the target audience, emphasized Brito. "Having all the groups harmonize their approach," she said, "guaranteed their support, as well as the support of others who saw the example of a product produced jointly to solve a problem."

And, said Brito, that close collaboration and use of multiple dissemination paths ensured that Dominican youth received a consistent message from NGOs, the media, their parents and their peers—much more often than "just one time." ■

AIDSCAP/DR



# Preventing HIV/AIDS by Promoting Life for Indonesian Street Children

by Bill Black and  
Arin P. Farrington

*Iwan beat up another student at school. Fearing his father's reaction, he fled his parents' home in the Indonesian city of Krawang*

*and moved to Jakarta, the country's capital. Since then, he has lived on the streets, making his living shining shoes, stealing and trading sex for money. Another street youth introduced him to sex. Now 15 years old, Iwan has never used a condom. He has heard about syphilis, but not about HIV or AIDS.*

**An HIV/AIDS prevention program in Indonesia has given hope to children living on the streets and helped put children on the national policy agenda.**

*nals with a group of friends. He patronizes sex workers regularly but won't use a condom. Once he experienced genital itching and treated it with a lotion he bought from a drug peddler. Dede has heard about AIDS and knows it has no cure.*



*Pencil and paper in hand, 11-year-old Shinta makes her way to the makeshift shack that serves as her classroom in the alley where she lives.*

Pact

## “RESCUE/AIDS touched

their lives through a  
basic message that  
matters most—  
that someone cares.”

I wan, Siti and Dede live on Indonesian streets, but stories like theirs could be told by millions of other children in countries around the world. Their days are consumed with finding food and a place to sleep. In the struggle to survive, they live with violence and sexual exploitation. Many seek relief by drinking alcohol, sniffing glue or taking other harmful drugs.

Given these daily concerns, it is difficult to convince children and teenagers who live on the streets to focus on something as abstract as HIV/AIDS that may take years to manifest itself. The challenge is to give them a reason to change behaviors that help them survive today but increase their risk of developing HIV/AIDS in the future.

This challenge was taken on by RESCUE/AIDS, a 16-month pilot project targeting street children in Indonesia. Conducted by Pact Indonesia with support from the AIDS Control and Prevention (AIDSCAP) Project, RESCUE/AIDS grew out of Pact's previous work with Indonesian nongovernmental organizations (NGOs) to connect underserved street children with social services. The pilot project ended in September 1996, but its success led to continuation under the HIV/AIDS Prevention Program (HAPP), implemented by AIDSCAP and funded by the U.S. Agency for International Development (USAID) and the Government of Indonesia.

### Surviving on the Streets

Some 4,000 to 20,000 children live on Jakarta's streets. According to Pact surveys conducted with Atma Jaya University, 25 percent are younger than 11, 15 percent are homeless and 40 percent live in slum rooms with other children. Understanding how these children live was fundamental to planning HIV/AIDS interventions.

“The street population is diverse,” said Dr. Anne Scott, director of Indonesia programs for Pact. “You can have a 17-year-old who follows his cousin to the city for a job. It doesn't work out, he doesn't get a job, but he doesn't want to

go back home until he's 'successful.' You can also have children fleeing from a violent family, where a 15-year-old and his 6-year-old brother came together.”

Many street children left home after getting into trouble—doing poorly at school, fighting or committing a crime. Some were sent away by parents who could not care for them. Others were orphaned. Still others have parents who maintain street-based businesses. About nine out of ten street children are boys, but the number of girls is increasing.

Once on the street, marginalized by and from society, street children are driven by the economics of survival. Some earn a living by singing, shining shoes, cleaning car windows, carrying packages or selling items such as candy, cigarettes, newspapers and magazines. Others become pickpockets or commit more serious crimes.

### Facing Sexual Threats

Street culture often encourages and reinforces risky behaviors. Street children reported that being forced to have sexual intercourse was one of the greatest problems they faced in living on the streets.

Many street children seek out the physical protection of an older youth, but that kind of partnership can be dangerous. “There are relationships on the street much like in a prison culture,” Dr. Scott said. “The younger boys need the protection of an older boy for survival, but it puts them at risk sexually.”

A 1995 assessment conducted by Pact and the Atma Jaya Research Center suggested that older youths often use anal intercourse as a rite of initiation with younger street children they are “protecting.”

Adults wishing to purchase sex are also a threat to street children. Some believe that youngsters are less likely to be infected with HIV than older persons and take advantage of their desperation and gullibility, promising special gifts in exchange for sexual services.

In addition, many of the older street children maintain relationships with sex workers. “It's more of a comforting re-

lationship with an older female figure, like a mother they didn't have,” Dr. Scott said. “But that's a direct bridge for the transmission of sexually transmitted infections.”

Most street children are poorly equipped to combat such sexual threats. In Indonesia, Pact found that few had accurate information about HIV/AIDS or other sexually transmitted diseases (STDs) and many held misperceptions about effective cures and prevention.

In general, street children had received little education, and compounding that lack of knowledge was a fatalistic world view. “We designed the pilot project because we saw that there is a link between basic health issues—what we call ‘perception of life’—and AIDS,” said Yustina Sari, Pact's RESCUE/AIDS project director. “Why should I care about life; what's the difference between life and death?” was the attitude of many street children.”

Instilling in street children a sense that life is worth preserving would be the first step in reducing their risk of HIV/AIDS. First, however, the messengers had to be clear about the message.

### Educating the Educators

A group of 10 Indonesian NGOs that had been involved in Pact's earlier work with street children were chosen for the RESCUE/AIDS project. As in the earlier projects, street educators formed the link between street children and the NGOs. They were a diverse group: some were graduate students in social work, some came from religious backgrounds and some were former street children. Most were in their early twenties.

“They were very dedicated,” Dr. Scott



*An Indonesian NGO street educator teaches street children not only in the classroom, but wherever it is possible.*

Pact

said. "They became like big brothers or big sisters to the street children."

These close relationships made it possible for the educators to talk to street children about sensitive issues. However, Pact found that many street educators themselves needed to know more about STDs, including HIV/AIDS. Before the project started, less than half of the street educators knew how HIV/AIDS was transmitted.

"In general, the street educators needed more basic knowledge of the human body and health, sexual reproduction, STDs/HIV/AIDS and condoms—what they are, how to talk about them and how to use them," Sari said. "Communication techniques, basic counseling and referral systems also needed improvement."

None of the educational media available at the time targeted street educators or street children. So Pact developed its own training materials and manuals that covered basic facts about HIV/AIDS, STDs and other reproductive health issues, as well as communication, outreach and counseling.

Another challenge was the street educators' attitudes and emotions concerning sexuality. Because of Indonesia's social traditions, women are expected to be more conservative than men in their views regarding sex, posing a dilemma for some of the female street educators.

Even when individuals felt comfortable discussing sexual issues with street children, not all of their NGOs fully backed them. Some groups believed other issues were more important than HIV/AIDS in improving the children's lives. Other NGOs opposed condom promotion, favoring moral education. "What we learned is that attitudes on moral issues determine the commitment of NGO management, and this determines the success of the field work," Sari said.

Two of the original ten NGOs chosen for RESCUE/AIDS were not able to continue work in HIV/AIDS prevention, even though their street educators were strongly committed to the issue. "The board of directors and project management did not agree, so they could not consistently support their street educators," Sari said.

Other NGOs, however, became more supportive as they continued to work with Pact, enabling their street educators to have frank discussion with street children about HIV/AIDS and sex and to promote condom use.

According to Joyce Djaelani, who served as an outside evaluator, the impact of the RESCUE/AIDS project extended beyond the street children to the NGOs and the community. "RESCUE/AIDS increased awareness of sexual abuse happening among street kids and substance abuse," said Djaelani, who is an Indonesia program officer for the Program for Appropriate Technology in Health (PATH). "And it also encouraged creativity among the NGOs in developing information, education and communication (IEC) materials for AIDS education purposes."

Participating NGOs gained skills in project and financial management, human resources and time management and learned about model HIV/AIDS intervention strategies. "Part of Pact's achievement is building the capacity of indigenous community-based organizations and NGOs to learn the management and technical skills necessary to implement programs such as this one," said Kari Hartwig, program officer in AIDSCAP's Asia Regional Office in Thailand.

### Getting the Message Across

Three different approaches were used to reach more than 1,000 street children with integrated messages on HIV/AIDS, self-care and life skills. Some of the NGO street educators approached young people where they congregated in public parks, bus terminals, markets, street corners and shopping centers. Others met them at community centers or in school classrooms. A third group allowed street children to come and live temporarily at small residential facilities that provided shelter, along with education and skills development.

All the children received basic literacy and health education. For younger children, general information about HIV/AIDS and other STDs was conveyed through simple messages. Older street youth received more complete information about HIV transmission and prevention and assistance in assessing their own personal risk and developing prevention strategies.

Since many of the children had dropped out of school and had limited reading skills, several NGOs used games to hold their attention and convey HIV/AIDS prevention messages. Comic books, stickers, posters and booklets with lots of illustrations and simple text were also created for the same purpose, with advice and training from Pact. Some of the children made batiks or T-shirts bearing HIV/AIDS prevention messages. Street children also helped develop some of the educational materials.

In the community centers, street children worked closely with the street educators. They decided together how to maintain the center and schedule the activities. "It was a bottom-up participatory activity," Sari said. "Most of them felt like this was their home."

"We built a sense of friendship and solidarity in this sense, hoping they would protect themselves and each other," she added. For example, one group of street children drew up a list of concerns and solutions. Sleeping on the street at night where they felt vulnerable to sexual abuse was considered a main concern. Their solutions included trying to find a mosque to sleep in, sleeping with a group of friends or coming to the nearest RESCUE/AIDS center.

Whenever possible, the NGO staff members mentioned HIV/AIDS in counseling sessions and informal discussions with individual street children. HIV/AIDS was discussed with other health issues, such as eating the right kinds of food, avoiding illegal drugs and watching out for traffic in the streets.

"The focus of the project was more broadly on risk behavior, about saying 'no' to risks and about why they were sometimes doing dangerous things," Dr. Scott said. "For example, when one child was hit by a car after sniffing glue, street educators took the opportunity to raise safety and self-care issues with the children who wanted to know what had happened to the injured child."

One of the major accomplishments of the project was getting street kids to take better care of themselves. "RESCUE/AIDS touched their lives through a basic message that matters most—that someone cares," Djaelani said. "When you feel that someone cares, you are less fatalistic in life. Any kindness makes a whole lot of difference to these kids."

### Making a Difference

During the past few years, Pact and other Indonesian NGOs have helped the government develop a national strategy



*Ati, 10 years old, and her friends are engrossed in their comic books. With assistance from Pact, Indonesian NGOs created comic books to teach street children how to read and to educate them in the skills they need to protect themselves—including HIV/AIDS prevention.*

on children that addresses the plight of street children.

"The project has certainly raised the issue of the vulnerability of youth and street children to policymakers," Hartwig said. "Reaching policymakers is key to long-term strategic change."

Public awareness of the vulnerability of street children has also grown. In 1996, media coverage of the rape, mutilation and killing of nine street children drew widespread public concern. And in September of that year, government agencies, NGOs and other organizations sponsored a three-day national conference on street children. "The government is developing an agenda with an infrastructure for street children," Dr. Scott said.

Changes in attitudes and behavior are also beginning to appear among street children. "Local organizations are saying that there is a group of younger kids who are aware of the danger they face," Dr. Scott said. "There is progress."

The importance of reaching Jakarta's street children with STD/HIV/AIDS prevention messages has been recog-

nized in the expanded activities of HAPP, which continued work started by RESCUE/AIDS under a new Underserved Youth (USY) Project in Northern Jakarta. The HAPP-USY Project also reaches youth who are informal dock workers, fishermen, factory workers, drivers and school dropouts.

Such work is increasingly important, Djaelani noted, as urbanization continues, and more and more homeless, friendless young people arrive each day in Jakarta. "The social gap is getting wider, slum areas are getting bigger, drug abuse is becoming more extensive," she said. "Children are our future: We can still make a difference in their lives, but if we turn our backs on them now when they are in need, in later years they will turn their backs on us." ■

*All photos were taken by NGO staff and street children. Pact Indonesia provided cameras so they could document their daily lives for a 1996 Congressional exhibit at the U.S. Capitol.*

# Jamaicans Begin to Embrace Safer Sex

by Kathleen Henry

---

## **A comprehensive, well-coordinated program to control HIV/AIDS and other sexually transmitted diseases is helping Jamaicans change their individual behavior and the way society views safer sex.**

*Give me the woman with the wickedest slam.*

*The one who know how fi love up she man.*

This hit song about a man seeking a partner with exceptional sexual technique became the vehicle for an important public health message on Jamaican television. "The wickedest slam is the one that don't give you an infection," says Beenie Man, a popular performing artist. "So remember: don't slam without protection."

The warning hits home in a society where rates of sexually transmitted diseases (STDs) are high and risky sexual behavior appears to be the norm for much of the population. During the past decade, studies in Jamaica have revealed widespread acceptance of sex outside of marriage or other stable relationships and a common perception that STDs are a natural and easily curable outcome of sexual activity.

But recent survey results suggest that these attitudes—and behaviors—are beginning to change. Jamaican men who once thought nothing of having five or more sex partners within a year are choosing their partners more carefully and staying in relationships longer. Men and women report having fewer sexual partners. And young adolescent boys are waiting until they're older to start having sex.

"I think we have begun to influence normative behavior," said Dr. Peter Figueroa, principal medical officer in Jamaica's Ministry of Health (MOH) and head of its HIV/STD control program. He attributes the program's success in influencing social norms to its comprehensive, systematic and sometimes unorthodox approach to HIV/AIDS prevention.

The program began in 1987 and soon attracted substantial support from international donors, particularly the U.S. Agency for International Development (USAID). With an overall HIV prevalence of less than 1 percent despite rates of 10 percent or higher in some groups and an epidemic fueled primarily by heterosexual transmission, Jamaica was seen as an opportunity to contain the epidemic's spread among the general population.

The USAID-funded AIDS Control and Prevention (AIDSCAP) Project took up that challenge in 1992. In most countries AIDSCAP works primarily—and sometimes exclusively—with non-governmental organizations (NGOs). But in Jamaica, USAID decided to provide AIDSCAP's technical and financial support primarily to the MOH through an existing agreement between the U.S. and Jamaican governments.

AIDSCAP staff and technical consultants worked closely with MOH staff to carry out the program from 1993 to

1996. "This linkage made it possible to combine our joint resources, expertise and efforts to reach more people with HIV/STD prevention resources," said Dr. M. Ricardo Calderón, who is director of AIDSCAP's Regional Office for Latin America and the Caribbean.

### **STDs a Priority**

From the beginning, the MOH integrated HIV/AIDS prevention into its STD program. For Dr. Figueroa, this decision typifies the willingness of program staff to flout the conventional wisdom and do what they believed was necessary to slow the epidemic in Jamaica.

"A majority of people coming into HIV/AIDS felt that was wrong—that STD programs were completely lifeless, bureaucratic and failures," he said. "But we built on the foundation we had here, and now world opinion has come around."

Combining STD and HIV prevention in one program helped ensure that messages about STDs were prominent in educational materials and outreach efforts. It also made improving STD services a high priority for the program.

Jamaica's STD program suffered from shortages of drugs, supplies and trained staff, long waits for laboratory results and increasing drug resistance. Researchers from AIDSCAP and one of its subcontractors, the University of North Carolina (UNC), worked with MOH staff to train health workers, upgrade clinics and laboratories, and study ways to improve STD services.

More than 5,000 public health care workers from government STD clinics in Jamaica's 13 parishes (districts) were trained in syndromic management of STDs, which enables them to prescribe prompt, effective treatment without expensive and time-consuming laboratory tests. During the summer of 1996, a study conducted by researchers who observed the management of patients with gonorrhea found that all the patients were treated correctly—up from 74 percent in 1991.

Most program efforts have focused

on improving STD prevention and treatment in government-run facilities. But recognizing that only about half of the STD cases in Jamaica are treated in public clinics, the MOH and AIDSCAP worked with the Medical Association of Jamaica to organize five continuing education seminars on STDs and HIV for private physicians. More than 55 percent of Jamaica's 1,100 practicing private physicians attended at least one seminar.

Physicians were impressed by the results of studies conducted by the MOH, UNC and AIDSCAP in Jamaica that demonstrated the effectiveness of syndromic management. Two months after the seminars, the number of participants reporting that they used this approach to treat urethritis and genital ulcer disease rose above 80 percent. Presentations of local drug resistance data also seem to have had an impact: before the seminars, more than 43 percent of participants had prescribed ineffective drugs to treat gonorrhea, compared to only 3.6 percent two months later.

### A Bold Move

The most dramatic improvement in STD services in Jamaica resulted from the decentralization of syphilis screening. Before decentralization, pregnant women and STD clinic clients who were screened for syphilis had to wait at least a week and typically up to six weeks for results to return from the two central government laboratories in Kingston and Montego Bay. "By that time, patients were gone, and women had delivered," said Frieda Behets of UNC, a technical consultant to the project.

Delays in diagnosis and treatment resulted in further transmission of the disease by people with symptomless syphilis and contributed to increases in the number of infants born with the disease. One study in Jamaica showed that fetal loss, stillbirth or infant death were almost twice as likely to occur when the mother had untreated syphilis.

The decentralization effort began at the Comprehensive Health Centre in

Kingston and was gradually expanded to other health centers and clinics. Laboratory aides and assistants with little laboratory experience learned how to perform syphilis blood tests at the clinics.

team. "Jamaica established one of the most comprehensive behavior change communication (BCC) campaigns we have seen," Dr. Calderón said. "This is a country that clearly defined the specific messages they wanted to convey to the

Norman Hall/National HIV/STD Control Programme



Two secondary school students look at the program for "Vibes in a World of Sexuality," a musical revue about HIV/AIDS, before a performance at a skating rink in Portmore, St. Catherine, during Safe Sex Week.

Many people were reluctant to endorse decentralization at first because they believed syphilis tests should be conducted only by laboratory technicians, according to Behets. However, a quality control assessment at the national reference laboratory showed that on-site testing was accurate: more than 96 percent of the results of syphilis tests performed by laboratory aides were confirmed.

Syphilis screening is now available at 76 antenatal clinics and 17 STD clinics in Jamaica. As a result, 68 percent of those who test positive for syphilis are treated the same day and 85 percent receive treatment in less than one week. More efficient and effective diagnosis and treatment contributed to a significant decline in infectious syphilis from 1994 to 1996.

### A Strategy That Works

Another strength of the Jamaica program was the MOH communication

population through public, private and NGO initiatives."

Communication team members used research results and lessons learned from previous communication campaigns to identify target groups and develop strategies and messages for each group. A message designed to help adolescents delay sexual initiation was supportive: "You are not alone." STD clinic clients' resistance to condom use was countered with "Increase the skills, increase the pleasure." And young adults with more than one sexual partner learned "Your partners' other partners are your partners too."

Every part of the communication strategy was well articulated and narrowly focused. For example, the target group of sexually active young adults was divided into men and women entering new relationships, women in need of condom negotiation skills, men with STDs and women with STDs. Messages were developed for each of those

Members of the Ashe Ensemble portray AIDS widows in a performance of "Vibes."

audience "segments."

What made the strategy work, though, was the careful coordination of all communication messages and activities, notes Donna Flanagan, AIDSCAP's associate director for behavior change communication. "The communication team met with implementers, media people and evaluators regularly, and they planned together what their strategies should be and how they could complement each other," she said. "It seems that this approach encouraged a national outlook and a climate of sharing that serve Jamaica well."

The communication team met every week. In addition to MOH staff, the team included a representative of Berl Francis and Company, Limited, the local agency MOH and AIDSCAP hired to carry out a public relations campaign targeting opinion leaders, young adults and adolescents. Making the agency representative a full member of the communication team ensured that the messages communicated through the media were consistent with those conveyed by outreach workers, peer educators and project materials.

Monthly meetings of a larger group known as the BCC team, with representatives from all the organizations involved in the HIV/STD program, enhanced that coordination. These meetings also provided opportunities to devise joint strategies for counteracting rumors and misinformation.

Flanagan explained that the BCC team "knew how to put out fires." "They could spot a trend in the early stages," she said. "Someone would say, 'We've been hearing a rumor in this parish,' and someone else would say, 'We've begun to hear that too—what can we do?'"



Nick Shears

Good communication and regular meetings also helped program and project managers use evaluation data to guide implementation. Annual meetings brought together representatives from the MOH, AIDSCAP, USAID, the collaborating NGOs and Hope Enterprises, the local firm that provided evaluation support, to discuss evaluation data and refine program and project strategies.

Technical assistance, training and oversight by the communication team ensured the quality and consistency of all educational materials and outreach efforts. Program activities reached almost three-quarters of a million people.

### Getting Through

One of the innovative features of the program was its use of public relations to influence youth and opinion leaders from the media, churches, the music industry and communities. Berl Francis staff wrote articles for Jamaican publications, including a weekly "Safer Sex" advice column, briefed opinion leaders and organized events.

Through its contacts with the Jamaican media and private sector, the Berl Francis agency was able to leverage U.S.\$181,818 worth of cash and in-kind contributions to the public relations

campaign. During the two-year campaign, the agency generated or assisted in the production of 64 radio and television programs and 421 newspaper and magazine articles about HIV/AIDS, including 167 articles written by Berl Francis staff.

"We realized we were getting through when the media managers became receptive," said Berl Francis, agency director. "We didn't have to bang on doors anymore. In fact, they started initiating requests for interviews, wanting to have further discussion on certain issues."

Dance hall disc jockeys helped the program gain access to the media by contributing their time to videotape and record public service announcements (PSAs) that aired on television, radio and the sound systems of dance halls. These performing artists have become wildly popular with Jamaican youth, primarily through live performances.

"Dance hall disc jockeys wield immense influence in the society," Francis explained. "Their lyrics both reflect social attitudes as well as influence ideas and behavior."

Beenie Man, who is particularly popular among young men, promoted condom use in two PSAs tied to his "Wickedest Slam" song. Lady Saw, whose explicit lyrics have earned her a



Norman Hall/National HIV/STD Control Programme

large following among men and women, appealed to men not to mistreat women who ask them to use condoms. She also taped a PSA aimed at women who resist condom use with the message, "It's not a matter of trust, it's reality."

The creativity of Jamaican musical stars, actors, comedians—and community members themselves—was an important ingredient of the communication strategy's success. Many of the projects that were part of the HIV/STD program incorporated drama, songs, games and other forms of entertainment into their activities.

The Targeted Community Initiative (TCI) enlisted the help of a famous Jamaican comedian to introduce sensitive topics such as HIV and condom use to inner-city communities. "The use of comedy was very effective," said TCI Project Manager Audrey Wilson Campbell. "It was non-threatening, but we were getting to the root of the issue."

Other talented artists performed in musical road shows for youth and at community gatherings. Projects also encouraged community members to develop and perform their own HIV/AIDS dramas.

Teens participating in the Jamaica Red Cross's peer education project pro-

vided the story line and other ideas for a radio drama about HIV/AIDS that aired twice a week, reaching an estimated audience of 60,000. And the MOH shot a video called "FRAIDS" in the inner-city neighborhood of McIntyre Lands that featured members of the community. "FRAIDS" and several other MOH-produced videos were shown on both local television stations.

#### Face to Face

The mass media coverage generated by the program reinforced the messages Jamaicans received from thousands of outreach workers, counselors, other public health staff and peer educators. The HIV/STD program worked with employers to establish prevention programs in dozens of workplaces and with social service workers to build HIV counseling skills. Its "Face-to-Face" Project filled rural communities with peer educators and its "Helpline" counselors provided advice over the telephone to thousands of callers. And TCI outreach workers used a community development approach in Kingston's disadvantaged inner-city neighborhoods, asking community members what kind of prevention services they needed.

Program staff emphasized the need to listen to members of the target audi-

---

*A well-known radio announcer, Fae Ellington of the Jamaica Broadcasting Corporation, distributes HIV/AIDS educational materials to visitors to a World AIDS exhibition at a popular shopping mall in Kingston.*

ences and remain flexible enough to adjust projects to meet their needs. The Jamaica Red Cross did this by involving young people in every aspect of its "Together We Can" project, including materials development. For example, the peer educators helped design a workbook with interactive instructional exercises to use in sessions with other teens.

The project's peer education sessions are popular with the target audience. "In many cases, going to a session has become a status symbol," Project Director Lois Hue said.

This popularity bodes well for the efforts of "Together We Can" and the MOH to make abstinence an accepted prevention option for young teens. Surveys suggest that more adolescents are abstaining from sex—particularly 12- to 14-year-old boys. From 1994 to 1996, the percentage of boys in this age group reporting sexual experience dropped from 59 to 41. One-third said they had been sexually active during the past 12 months, down from 40 percent.

Jamaica AIDS Support (JAS) also seeks to create a more supportive environment for behavior change. A grassroots NGO, JAS offers peer education and other prevention activities to marginalized groups, including gay and bisexual men, and provides counseling, support groups, testing, and home and hospice care to people living with HIV/AIDS and their families.

Many Jamaicans react to homosexuality with discomfort, contempt and sometimes even violence. These attitudes inadvertently promote HIV-risk behavior because they discourage stable, long-term partnerships between men. In response, JAS prevention efforts go

beyond education and condom promotion to build self-esteem.

"We preach a message to counter the one that says you are dirty and evil," said JAS Executive Director Ian McKnight. "It says, 'You can be a productive member of society, and because of that you need to protect yourself.'"

The message seems to be having an impact. A comparison of surveys conducted in December 1995 and August 1996 revealed a 40 percent increase in condom use among men who have sex with men and a 30 percent reduction in self-reported high-risk behavior.

For JAS, which began as an informal network of gay and bisexual men helping friends with AIDS-related illnesses, responsiveness to its target audience is simple. "We were already part of the community," McKnight said. "Over the years we have been able to establish a trust."

To reach two of the other groups hardest hit by the epidemic in Ja-

maica—STD clinic clients and female sex workers—the program turned to another local organization that had earned the trust of those target populations. The Association for the Control of Sexually Transmitted Diseases (ACOSTRAD), a Jamaican NGO founded in 1978, provided education at all parish STD clinics and other health centers as well as special outreach efforts to sex workers and their clients in the red light district of downtown Kingston.

ACOSTRAD opened drop-in centers in Kingston and Montego Bay to provide a more confidential, convenient place where sex workers could receive STD treatment, counseling and HIV testing. More than 500 sex workers were reached at centers and during visits to bars, clubs and brothels.

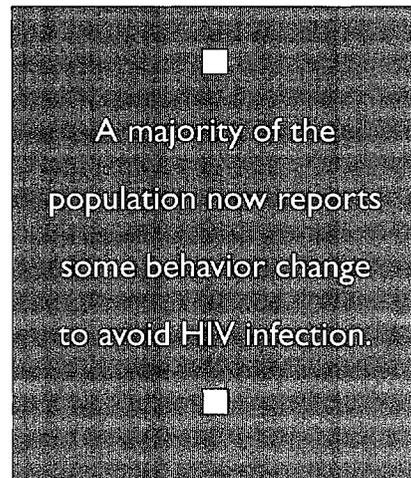
Like many other target groups, sex workers seem to be taking the outreach workers' messages to heart. Reported condom use with the most recent client has increased dramatically to 95 percent. Three out of four of the women report consistent condom use.

#### New Directions

AIDSCAP's collaboration with the MOH in Jamaica ended as scheduled in August 1996, leaving behind an experienced HIV/AIDS prevention team and improved STD services. USAID now funds the MOH HIV/STD program directly and expects to continue this assistance through the year 2001.

During the years of AIDSCAP support for HIV/AIDS prevention in Jamaica, knowledge of HIV prevention methods increased among all target groups. For the first time, lack of access is not the major reason cited for failure to use condoms, suggesting that the program's reliance on the private sector and targeted free condom distribu-

*Members of the Face-to-Face team and youth club use drama to entertain members of a rural community in Manchester and to educate them about the need to seek treatment for STDs.*



tion has been effective. And a majority of the population now reports some behavior change to avoid HIV infection.

Although people are changing their sexual behavior and HIV prevalence remains below 1 percent in Jamaica, Dr. Figueroa sees no reason for complacency. HIV prevalence is as high as 20 to 30 percent among some of the target groups, and surveys conducted by Hope Enterprises in 1996 identified continuing problems and new challenges for the HIV/STD program.

The results show, for example, that a growing proportion of the population is unaware that HIV/AIDS can be symptomless for many years and half of the men with STD symptoms seek inappropriate treatment or no treatment at all. The surveys also revealed widespread negative attitudes toward people living with HIV/AIDS, low rates of condom use among unemployed men and sex workers who use illegal drugs, and an increasing number of women and girls in inner-city neighborhoods turning to sex work or seeking additional partners in response to a decline in the Jamaican economy.

Perhaps the most important challenge for the program will be to support continuing changes in the social norms that influence individuals' sexual behavior. "We need to sustain the message, to help sustain the behavior," McKnight said, "but also to create an environment in which safe behavior is acceptable."

Norman Hall/National HIV/STD Control Programme



# HIV/AIDS and the Church: Kenyan Religious Leaders Become Partners in Prevention



Women from a Methodist church in Meru use song and dance to launch a local branch of the Kenya Christian AIDS Network.

by Bill Black

---

## In Kenya, winning over a skeptical clergy to the cause of HIV/AIDS prevention has created a powerful grassroots campaign based in the churches and the communities they serve.

**L**ike many pastors in rural western Kenya, Reverend Jacob Onyalo had long been reluctant to discuss HIV/AIDS in his church sermons.

"My community believed that AIDS affects only the 'immoral,'" he said.

But one Sunday, Rev. Onyalo stood at the pulpit, faced his congregation, and finally ended the silence on the disease that has plagued their nation for so long. He spoke of the need to show compassion for people with HIV/AIDS and to help care for them when they become sick, and encouraged his parishioners to protect themselves from HIV by avoiding extramarital and premarital sex. Since that breakthrough sermon, his congregation has heard him speak again and again about AIDS.

"Now I address AIDS in every message I give," he said.

The inspiration for these sermons comes from an "awareness packet" Rev. Onyalo received from MAP Interna-

tional, a nonprofit Christian relief and development organization. It included sermon outlines with the themes and information he needed to break the ice on HIV/AIDS with his congregants. This kind of outreach is a fundamental part of the unique program that MAP—with funding from the AIDS Control and Prevention (AIDSCAP) Project—has created to tackle one of the greatest challenges to prevention education in Kenya: a powerful religious leadership that has been divided about the epidemic and how to deal with it.

"Throughout the early 1990s, most religious groups in Kenya either ignored AIDS or explained it as the result of aberrant or immoral behavior," said Bill Rau, AIDSCAP's associate director for policy.

At one extreme, in fact, were religious leaders who led anti-condom crusades and rallies where HIV/AIDS brochures were burned, in the belief

that teaching people about prevention measures encourages promiscuity. But MAP staff were also aware that a much larger but far less vocal group of clergy hoped to find a way to express their sympathy for the human tragedy of AIDS and help prevent the epidemic's spread. The time had come to tap that support—and the MAP Kenya HIV/AIDS Project was born.

"The Kenyan people are very religious, and moral arguments from their church leaders and religious organizations are extremely influential," said Rau. "There are few other institutions in Kenyan society with such ability to change hearts and minds about this epidemic."

### Persuasive Data

Helping Kenyan religious groups confront the HIV/AIDS epidemic grew naturally out of MAP's decade of experience in Kenya working on health care

"Finally there was true acceptance by the religious community that AIDS is a

major problem and that they have a responsibility to do

and community-based development with churches, government agencies and other institutions. The organization's nondenominational status and the relationships it had built with religious leaders gave MAP the credibility to encourage church involvement in HIV/AIDS prevention and care.

Those links with the religious community had the potential to help MAP reach millions of Kenyans. In sheer numbers alone, churches are perhaps the most important grassroots organizations in Kenya. Some 70 to 80 percent of Kenyans belong to a Christian denomination.

"Churches in Kenya are right where the people are in the community," said Debbie Dortzbach, the first director of the MAP Kenya HIV/AIDS project. "There's a good structure for a multiplier effect when church leaders talk to their congregations."

What helped MAP motivate many of these churches to first get involved were eye-opening data collected from research surveys and focus group discussions conducted at the beginning of the project. Hoping to identify issues important to local churches and national religious organizations, the researchers reported findings that astonished many church leaders. They found that 32 percent of the pastors surveyed reported they knew other pastors who had been unfaithful to their spouses, and also that



*The late Ruth Kasuki is cared for by a friend from her church. A woman who lived with HIV/AIDS and a well-known church advocate, Kasuki continued to speak out about the need for Kenyan church involvement in prevention and care even on her deathbed.*

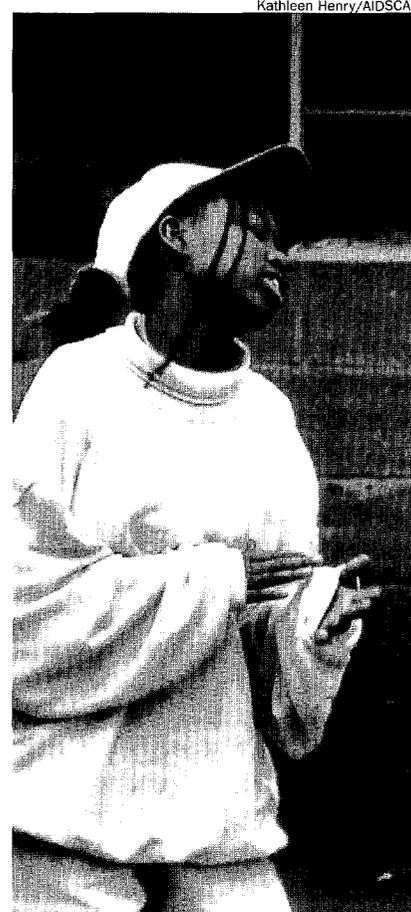
49 percent of young churchgoers had had premarital sex.

"One pastor came to me in shock," recalled Paul Robinson, the MAP project's second director. "He said that if this high a percentage of youth in our churches is sexually active, then we definitely have to do something about it."

Widespread misconceptions about HIV/AIDS that the surveys revealed also surprised many clergy, who had not realized how ignorant—and thus how vulnerable—many Kenyans were about the epidemic.

"In some areas of the country, AIDS cases were being treated as malaria or as a curse or a bewitching," said Robinson. "Only a third of the respondents understood it to be an epidemic."

*A Kenyan girl practices a song she will perform at a youth camp outside of Nairobi where MAP's materials are used to educate young people about HIV/AIDS.*



## Pastoral Counseling

In the MAP studies, ministers and priests cited counseling as one of their biggest concerns. Few of them had appropriate training in counseling HIV-positive persons and their families.

To fill that need, MAP created an intensive pastoral counseling course. It consisted of one week of introductory instruction, several months for the trainees to apply at home what they had learned, and then a second week-long session to review their experiences, further strengthen their counseling skills, and discuss sensitive issues such as cultural practices and prevention measures. Both workshops included case study discussions and counseling role plays.

The two-part counseling instruction was held six times, and 160 ministers, priests and other church leaders participated. Far exceeding MAP officials' expectations, trainees conducted more than 575 counseling sessions, educational meetings or other activities in the months between the first and second workshop sessions, reaching more than 56,000 persons in churches, schools, health centers, government agencies and elsewhere.

A 50-page counseling manual MAP had developed earlier helps trainees and other clergy members counsel HIV-positive individuals and their families. It covers basic counseling skills such as how to listen and ask questions, how to help an individual develop a personal prevention action plan, and how to give advice and encouragement, as well as specific questions and concerns about HIV/AIDS. It also suggests ways to help people and families living with HIV/AIDS find significance in life and deal with feelings of loss and grief. Like other MAP materials, the manual cites Bible passages that reinforce the counseling messages.

To provide additional background for pastoral counseling work, MAP created two other manuals. "Facts and Feelings about AIDS" covers basic medical information about HIV and AIDS and helps users deal with their concerns

about the epidemic. "AIDS in Your Community" guides readers in researching the extent of the problem in their regions and the available resources to help them tailor a response to local conditions and plan an effective HIV/AIDS education program.

MAP printed 2,000 English-language copies and 1,000 Kiswahili translations of each of the three manuals and distributed them mainly in the four regions of the country where the project has focused its efforts. The majority of Kenyans live in those areas, which are also the ones most heavily affected by the HIV/AIDS epidemic.

Another resource for clergy members, MAP's awareness packet, draws on the Scriptures to help clergy members broach sensitive issues of sexuality, morality and HIV/AIDS. It includes the sermon outlines that Rev. Onyalo found so helpful, such as "Are You a Good Shepherd?" which deals with compassion and care, and "The Sure Solution," which promotes abstinence and fidelity. The awareness packet also contains posters, brochures and a Bible study text, "The AIDS Challenge."

In order to encourage Kenya's various religious groups to institutionalize the use of these materials, MAP has included them in a package of curriculum modules. Several of the country's major denominations are now considering officially adopting them for use in their theological or pastoral training institutions.

## Growing Together

Another concern MAP identified through its research was the lack of communication between parents and children about HIV/AIDS and other sex education issues. The problem was in part cultural: traditionally, young Kenyans learned about sex from their aunts, uncles or grandparents, but with growing urbanization and the decline of the extended family, that important source of information no longer exists for many youth.

"Young people said they were learning about sex and AIDS from their peers

and the mass media, but they wanted to get more information from their parents," reported Ndunge Kiiti, who served as director of communications in MAP's eastern and southern Africa regional office in Nairobi, Kenya.

To help parents bridge this difficult communications gap, MAP developed a guide entitled "Growing Together."

"It's something a family can walk through together and use in their own way," Kiiti said.

Within three months of its initial printing, 5,000 copies of the guide had been distributed through churches and a series of day-long workshops for religious leaders, churchgoers and the general public. The demand for the guide was so high that MAP had 6,000 additional copies printed.

Clergy members use the guides to help advise parents and to improve their own communication with young churchgoers. MAP's startling research findings on youth sexuality have inspired a growing number of churches to establish special programs for young people. The Methodist Church, for example, assigned a pastor as the full-time director of a new HIV/AIDS prevention program for youth in the Nairobi region.

## Broad Consensus

Another fundamental component of the MAP program was its work with leaders of Kenya's various denominations on policy issues. MAP conducted periodic policy workshops and confer-

"Young people said they were learning about sex and AIDS from their peers and the mass media, but they wanted to get more information from their parents."

ences for church officials, helping to establish the Kenya Christian AIDS Network (KCAN), an organization for religious groups to share information and resources and to encourage church-policy reform. Since its establishment in 1994, KCAN has grown to include 30 local and regional branches.

In November 1994, religious leaders met and adopted a short general position statement on HIV/AIDS, committing churches to a "ministry of Christian hope, reconciliation and healing in our congregations and communities through prevention, education and care for persons and families." Although it was only two sentences long, the declaration was the Kenyan religious leadership's first unified public statement on HIV/AIDS, and it has served as a cornerstone for later efforts.

**Respect for alternate views is a guiding principle for MAP.**

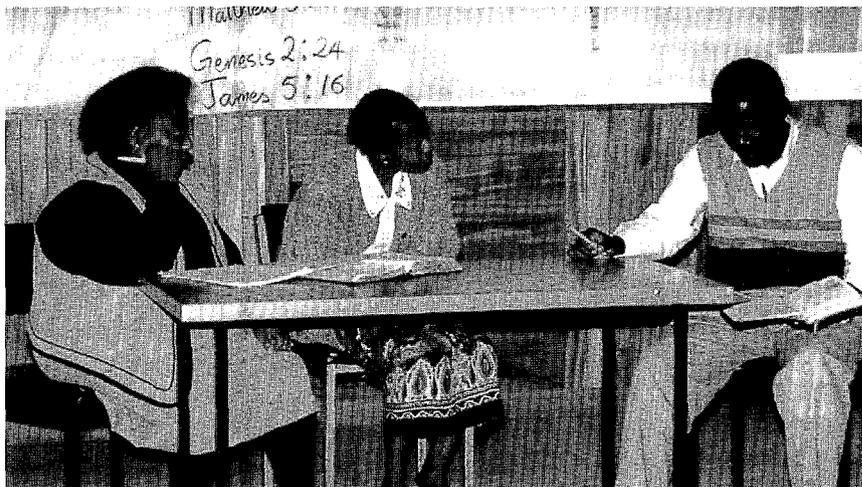
The pronouncement has helped keep the various denominations unified in the face of dissension, reported Dortzbach.

"When we had disagreements, we'd go back to that statement as a call to unite around," she said. "That was common ground that everyone could relate to."

Respect for alternative views is a guiding principle for MAP. In the pastoral counseling training, for example, the potentially divisive issue of condoms was incorporated into a session on helping "discordant" couples with one HIV-positive spouse and one HIV-negative spouse. Trainees voluntarily divided themselves into two groups, one to discuss condoms and the other to consider abstinence and nonpenetrative sex. After their separate deliberations, the groups shared their conclusions with one another.

"It worked out well," said Kiiti. "It was nonthreatening, and the two groups learned from each other."

Religious leaders met again in Feb-



*Pastoral counseling workshop participants in a role play of a counseling session with an HIV-discordant couple.*

MAP International

ruary 1996 and expanded on the position statement with a list of 14 HIV/AIDS priority issues on which churches should develop policies. They included providing education on family life and sexuality, developing support groups, implementing premarital counseling and HIV testing, caring for orphans and people living with AIDS, and supporting the rights and needs of women.

The leaders also said churches should develop policies on "appropriate and acceptable methods of protection" without naming any specific practices, such as condom use. And in an unprecedented acknowledgement that clergy members do not always practice what they preach, they called for a revitalization of moral values in church leadership.

"At this point, the tide really turned," said AIDSCAP's Bill Rau. "There were still a few priests publicly bashing prevention efforts, but finally there was true acceptance by the religious community that AIDS is a major problem and that they have a responsibility to do something about it."

**Changing Attitudes and Behavior**  
MAP's comprehensive approach has had a significant impact on Kenyan church involvement in HIV/AIDS prevention and support, according to surveys conducted in the fall of 1996 with religious leaders and with youth who

regularly attend church. Results from regions where MAP had and had not worked showed that churches in the MAP areas were more likely to provide home care for people living with HIV/AIDS, develop peer counseling programs, and hold retreats and other marriage enrichment activities.

Only 42 percent of church officials in MAP areas said they would be likely to counsel the use of condoms when one marriage partner was unfaithful—but that was higher than the corresponding 30 percent in other areas of the country.

Sexual activity had actually increased during the two years among all church-going youth surveyed. Sixty percent said they had had sexual relations at some point, versus 49 percent in the baseline study two years earlier. Nevertheless, in the MAP areas only about 10 percent of the church youth had had more than one sexual partner in the preceding six months; in non-MAP areas, the figure was 30 percent.

Differences like that make MAP officials optimistic that the evolution experienced by church leaders will produce further changes in the behavior of congregation members.

"The project created an awareness in the church, and helped put new policies into place," Kiiti said. "In the future I think we'll see even more behavior change." ■

# The Race

## to Beat AIDS on the Lao-Thai Border

by Prudence Borthwick

CARE/Lao PDR

**Creative prevention activities along the Lao-Thai border show that traditional festivals can offer unique opportunities to raise awareness about HIV/AIDS and promote safer sex.**

During the Boat Race Festival in the Lao People's Democratic Republic (PDR), people throw aside their inhibitions. "Old people say the festival is a time when people are supposed to do mad things, to turn things upside down, so that the gods will stop the rains," a Lao colleague explained.

But in several border towns during last year's festival, the antics of some participants surprised even veteran observers of boat festivals. Middle-aged women danced in the streets with condoms, rowers paddled past in T-shirts emblazoned with a condom cartoon character and performers sang about how to avoid the AIDS virus.

Condoms and HIV/AIDS prevention messages were a prominent part of the Boat Race festivities held October 26-28, 1996, in the capital, Vientiane, and two other Lao towns across the Mekong River from Thailand. Mass education, condom distribution and outreach activities during the festival marked the launch of an innovative safer sex promotion campaign designed by the AIDS Control and Prevention (AIDSCAP) Project and CARE International to reach people from both sides



At the Boat Race Festival opening ceremony in Huai Sai, rowers wear T-shirts with HIV/AIDS prevention messages.

of the river with timely HIV/AIDS prevention messages and methods.

### Early Warning

The communication campaign in the Lao PDR is one of a number of AIDSCAP projects promoting safer sexual behavior among cross-border populations in Asia. Funded by the U.S. Agency for International Development (USAID) and implemented by CARE,

the Lao project targets people who regularly traverse the Lao-Thai border and their sexual partners.

Unlike Thailand, the Lao PDR has low rates of HIV infection. The most recent data, from March 1995, show that 59 of the 20,700 people who had been tested for HIV were infected with the virus. But a February 1994 assessment conducted by AIDSCAP and CARE along the Lao-Thai border sounded a

A 1994 assessment sounded a warning that Laotians cannot afford to be complacent about the HIV/AIDS epidemic.

warning that Laotians cannot afford to be complacent about the HIV/AIDS epidemic.

The assessment report describes a porous border, with hundreds of thousands of tourists, traders, businessmen, truckers, migrant workers and transient tribal minorities crossing from Thailand into the Lao PDR each day. "Due to the dynamics of border movements where people seek entertainment and develop casual and commercial sex contacts among populations in Thailand with high HIV infection rates, the Lao PDR is rapidly approaching the exponential growth phase of the epidemic curve," the assessment team warned.

To avert escalation of the HIV epidemic in the Lao PDR, assessment team members recommended a comprehensive set of interventions aimed at reducing sexual transmission of the virus. One of these interventions, the CARE/AIDSCAP communication campaign to encourage sexual behavior change among vulnerable border and urban populations in three provinces, was funded by USAID and approved for implementation by the Lao National

Research in neighboring Thailand suggests that some festivals provide opportunities for HIV transmission.

Committee for the Control of AIDS (NCCA) in 1996.

CARE collaborates with the government and other important sectors of society to realize the project's goals. Project working teams in each province include representatives of CARE, the provincial AIDS committee, the Lao Women's Union, the Youth Union and trade unions. These teams held focus group discussions with members of the target groups to enlist their help in developing effective messages and materials. They also worked with the NCCA and the provincial AIDS committees to determine the best time to launch a safer sex promotion campaign.

#### Festival Time

Experience with HIV/AIDS interventions suggests that timing can be crucial to their success, yet the timing of most HIV/AIDS prevention activities is dictated by administrative requirements. Opening and closing ceremonies or launches of new communication materials, for example, usually take place at times convenient for the organizers. Internal scheduling constraints are sometimes unavoidable, but with careful planning it is possible to tie project activities to events of local significance, to greater effect and at little or no extra cost.

In the Lao PDR, the traditional festival season following the Buddhist Lent seemed an opportune time for launching HIV/AIDS prevention activities. Although no studies have examined sexual behavior and HIV/AIDS risk during Lao festivals, research in neighboring Thailand suggests that some festivals provide opportunities for HIV transmission. In northern Thailand, sexually transmitted disease rates increase noticeably at the end of April after the three-day *Songkran* (Thai New Year) celebrations. There are also accounts of commercial sex and casual gay sex being negotiated at temple fairs in rural areas.<sup>1</sup> And certain hill tribe New Year celebrations in both Thailand and the Lao PDR are known as occasions for courting and sexual activity.

Of course, not every festival is suitable for condom promotion, as HIV/AIDS organizations found when they asked whether they could include a banner in a solemn religious procession during one festival. However, the fairs and dances that accompany such occasions may provide opportunities for discreet and carefully targeted condom distribution. Other religious festivals, such as Thailand's *Thod Pa Bam*, when Buddhists donate robes and other necessities to monks, have been used to promote the need for care and support of people living with HIV/AIDS.

*Awk Phansa*, the end of the Lenten period of fasting and penitence, signals the beginning of the festival season in Thailand and the Lao PDR. It marks the end of the rainy season and the end of the period when Buddhist monks are confined to their temples. A number of traditional festivals occur after *Awk Phansa* in the Lao PDR, starting with the Boat Race Festival in late October and ending with the Lao New Year in early April. These occasions are celebrated by feasting, dancing, games and other fun. Part of the fun is drinking—and sometimes having sex.

During the Boat Race Festival, thousands of spectators line the banks of the Mekong River to cheer on teams from different villages and city districts. Both men's and women's teams row long boats in a series of heats culminating in a final race. Before each race, long lines of dancing, joking villagers escort the rowers to their crafts. Some dancers paint their faces and carry phallic carvings.

Such festivals provide an opportunity for mass communication as town populations swell with villagers from outlying areas, visitors from other provinces and tourists from other countries. These opportunities are often employed to great advantage by private enterprise: at the most recent Boat Race Festival in Vientiane, for example, huge banners on barges floating mid-river advertised such products as Marlboro and Dunhill cigarettes and B&W whiskey.

CARE decided to use the festival to



*A large paper boat waits in "dry dock" for the boat race festival. During the festival, people build boats out of paper, banana leaves and flowers to float down the river.*

Kari Hartwig/AIDSCAP

promote a healthier "product"—safer sex. Different activities were planned for each of the project sites, but in all sites the focus of the activities was, naturally, the Mekong River.

#### Targeted Distribution

In Vientiane, a fair is held along the river bank every night during the Boat Race Festival, with bands performing at open-air dance floors. It would have been possible to hand out condoms to fairgoers or to the crowds watching the races, but a limited supply of condoms was available. Taking their cue from a study that questioned the value of mass condom distribution during carnival celebrations in São Paulo, Brazil (only 9.7 percent of participants reported engaging in risky behavior during the festivities),<sup>2</sup> project planners worked with the NCCA secretariat to devise a strat-

egy that would get condoms to those who needed them most.

CARE staff made cardboard "point of sale" display boxes bearing the campaign logo, filled them with condoms and placed them in men's toilets at drink shops, restaurants and nightclubs near the river during the festival. In some cases, male CARE staff members stood by the display to explain why the condoms were there and how to use them. The outreach and condom distribution was conducted at the start of the festival each day, where possible before the nightspots began to fill up, and at intervals during the evening.

The condoms were well-received by male and female bar workers, band members, announcers, management and clients alike. As CARE staff arrived at one nightclub, workers crowded around to find out what they were car-

rying. Upon learning that it was a box of condoms, all the men and some of the women immediately demanded their share. The club owner helpfully instructed his employees to leave the condoms in the display boxes for patrons because condoms would be distributed directly to staff. Two hours later, club employees greeted CARE staff with smiles and laughter, announcing that almost all the condoms were gone.

By this time it seemed that condoms had become the theme for the evening. The master of ceremonies was making announcements from the stage about using condoms and said that he would sing a song of his own composition about them. He proffered free condoms on stage to anyone who wanted them. Amid clapping and cheering from staff and other patrons, two men walked up from the table where they had been sit-

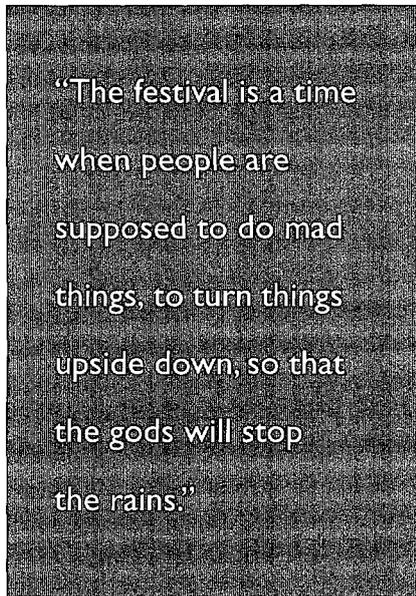
ting with friends and bar girls to claim their condoms. One bar patron told a CARE worker that he deeply appreciated such efforts to protect peoples' health.

The simple logo and message designed for the Boat Race Festival in Vientiane featured a cartoon of a condom in a boat raising a paddle aloft in victory with the message, "*Sai Tung Yang Anamai Sana AIDS Touk Hop*" (Using a condom you beat AIDS every round). Both were printed on small posters and T-shirts.

The most memorable display of the logo occurred when some members of a village women's group wore the T-shirts as they danced their village's team down to the river. (Other members of the group wore T-shirts distributed by the Australian Red Cross or the NCCA.) CARE also provided these middle-aged women with condoms to display during the dance. One of the women had brought two little plastic snakes as part of her "act." This mother of six and grandmother of fourteen nearly collapsed with laughter as she demonstrated putting the condom on over a snake's head.

### Joining the Race

The CARE working teams organized a variety of prevention activities in Huai



"The festival is a time when people are supposed to do mad things, to turn things upside down, so that the gods will stop the rains."

Sai, a northern Lao town of 40,000 people that lies just across the river from Chiang Rai, one of the Thai provinces hardest hit by HIV/AIDS. Each of the 291 rowers participating in the boat race received and wore a T-shirt printed with a condom cartoon and an HIV/AIDS awareness message. During the races every rower had a large cartoon condom on the back of his or her T-shirt, recognizable from a considerable distance.

T-shirts were distributed before the festival to members of the project's specific target groups: 66 drivers of *samlors* and *tuk-tuks* (local variations of the motorized rickshaw) and 55 speedboat drivers. While they were distributing the T-shirts, CARE staff ran entertaining HIV/AIDS educational sessions for groups of about ten drivers at a time, using group discussions and playing games to teach the men how to prevent HIV transmission.

The condom rower logo appeared around town on photocopies made by CARE staff and posted in small drink shops, restaurants and public places along the riverbank. Some tuk-tuk drivers asked for copies of the poster to display on their vehicles.

On the day of the festival, Huai Sai was a sea of HIV/AIDS T-shirts worn by the Boat Race Committee members, heads of provincial government departments, rowing teams and drivers. Race announcers read HIV/AIDS prevention messages over the public address system. Many people were heard to remark on "the AIDS explosion." In fact, at the illuminated boat festival, where small decorated "boats" carved from banana tree trunks are floated down the river, the winning boat bore an AIDS logo carefully copied from the image on the T-shirts, although the entrants had not been part of any of the education sessions.

At the third project site, Pakse in the southern province of Champassak, the rowing teams were also decked out in condom T-shirts. The drama troupe of the Provincial Department of Information and Culture performed for race

spectators, and songs with prevention messages were sung at an open-air concert by the river, reflecting the southerners' traditional skills and interest in music.

Encouraged by the enthusiastic response to these activities during the festival, the Pakse project working team planned outreach and education visits to factory workers at the end of each month. Visits are scheduled to coincide with pay day, which workers have acknowledged is the time they are most likely to go out for a night on the town.

The teams in each project site continue to make links with local events wherever appropriate. During the 1997 celebrations of the International New Year, for example, two safer sex posters produced for bar workers and patrons were handed out as New Year gifts.

More research is needed to understand the potential role of festivals and other celebrations in HIV/AIDS prevention. But it was evident that the project working teams were able to make the most of opportunities offered by the Boat Race Festival in the Lao PDR, reaching large numbers of people with prevention education, condoms and advice on safer sex at times and places where they were most likely to be applied. ■

---

### References

1. NAPAC. 1995. A visit to Ban Dong Luang. Northern AIDS Prevention and Care Programme newsletter 2(2).
2. Hughes V, RD Stall, C Klouri, et al. 1995. AIDS risk-taking behavior during Carnival in São Paulo, Brazil. AIDS 9(suppl 1): S39-S44.

---

*Prudence Borthwick, now coordinator of the HIV/AIDS and International Development Network of Australia (HIDNA), served as health advisor to the CARE/AIDSCAP/NCCA project in the Lao PDR for four months in 1996. From 1993 to 1995 she worked with the Northern AIDS Prevention and Care Programme in Chiang Mai, Thailand.*

# Border Crossings and HIV: AIDSCAP Identifies Environmental Risk

The environment that mobile populations encounter on their travels may be a more significant HIV risk factor than their own attitudes or habits.

HIV/AIDS prevention projects in many countries have targeted transport workers, military troops and other populations whose transient life styles seem to make them particularly vulnerable to HIV infection. Such projects usually promote individual behavior change. But results from a series of studies sponsored by the AIDS Control and Prevention (AIDSCAP) Project suggest that the environment that these mobile

populations encounter on their travels may be a more significant HIV risk factor than their own attitudes or habits.

Since 1994, AIDSCAP has commissioned five studies of mobile populations in border areas in Asia to assess their level of risk for HIV and identify opportunities for prevention interventions. Studies were conducted in port towns in Papua New Guinea, fishing ports and land crossings along the Thai-Cambodian border, truck crossings between India and Nepal, port cities connecting Indonesia and the Philippines, and river trade routes and land border crossings between Thailand and the Lao PDR.

The initial focus of the assessments was the mobile populations found in these border-crossing areas. But as the results from the various studies accumulated, an interesting hypothesis began to emerge: Perhaps it is the atmosphere of a border-crossing, more so than a traveler's motivation, that encourages uninhibited behavior.

All five studies found a distinctly higher concentration of options for risk behavior in the border-crossing areas than in other urban locations farther from international borders. These include a multitude of low-cost drinking establishments and opportunities for low-fee commercial sex. The common wisdom holds that mobile men with money are prone to engage in HIV and STD risk behavior along their routes of travel. However, the destinations along the way may act as transmission zones where multiple, anonymous partner sharing is intense. This phenomenon is even more apparent at a border crossing than in an average trade town.

Are individuals with a tendency toward risk behavior attracted to migratory lifestyles, or does an environment remote from family, community and law enforcement encourage such behavior in otherwise low-risk individuals? Both explanations may apply—any single answer to this question would be a simplification of a complex situation. What we can say is that in addition to prevention activities for individuals on-the-go, there is a need for more contextual interventions that address the risk environment in cross-border sites. Examples of possible structural interventions in these locations include:

- condom-only brothel policies that are promoted and enforced by brothel managers, border authorities and local health officers in cross-border towns.
- aggressive social marketing of single-dose, effective antibiotics to treat STDs through all pharmacies and drug sellers in border-crossing locations.
- free condom supplies in all brothel bedrooms and all hotel and rest-house bedrooms.
- mass media themes that characterize the border-crossing environment as flammable for STD and HIV outbreaks at any time.
- mass treatment for STDs via periodic campaigns or mobile "reproductive health" vans stationed in border towns.

These interventions could be costly. However, if—as suggested by the AIDSCAP findings—more HIV transmission per capita occurs in these border zones of high risk than in other areas, then the cost per infection averted could be attractive to national and regional prevention programs.

—Tony Bennett

*Tony Bennett is senior program officer in AIDSCAP's Asia Regional Office in Bangkok, Thailand.*

Copies of any of the five assessment reports and two other AIDSCAP documents about HIV risk and potential interventions in cross-border environments are available free of charge from AIDSCAP/Family Health International, Arwan Building, 8th Floor, 1339 Pracharaj 1 Road, Bangkok 10800, Thailand. Fax: (662) 587-4758.

# Saving a Generation: Ethiopian Youth Rally

THE UNITED NATIONS AIDSCAP PROJECT

by Kathleen Henry



Sean Sprague/Impact Visuals

Boys play in the street in the town of Mekele. AIDSCAP-supported prevention projects for out-of-school youth targeted children as young as ten and adults in their twenties.

*Fassil Nebyeleul was a 21-year-old university student when AIDS claimed one of his best friends.*

The death shocked Fassil and his mates. They had never imagined that HIV could hit so close to home. But they knew the behavior that had led to their friend's death was no different from their own.

"We decided that we were all HIV-positive and calculated our time of death as four or five years," Fassil said. "So we said, let us do something before our lives are gone."

What they did was organize a group called Save Your Generation to warn other young people about the threat of HIV/AIDS. Each of the five founding members invited five friends to the first meeting, where they talked about how

to prevent HIV transmission and urged new members to spread the word.

From that original group, Save Your Generation Association (SYGA) has grown into a registered Ethiopian non-governmental organization (NGO) with a paid staff of 14 and more than 6,000 dues-paying members. The founding members (who later learned that they were not HIV-positive), are very much alive and have expanded the organization's activities well beyond the university community. Most of their efforts are aimed at saving Ethiopia's lost youth—the tens of thousands of school dropouts and other unemployed young people who are particularly vulnerable

to HIV/AIDS.

SYGA is one of seven NGOs that received support from the AIDS Control and Prevention (AIDSCAP) Project over three years to bring HIV/AIDS prevention education to out-of-school youth in six urban areas. These projects have enlisted the help of young volunteers and community organizations to inform and motivate a segment of the Ethiopian population that is difficult to reach and very much at risk.

## Out of School, Out of Hope

The United Nations defines youth as the ages from 14 to 24, and most HIV/AIDS prevention programs for youth target

people in that age group. But in Ethiopia, where unemployment is high and many people live with their families long after they leave school, the AIDSCAP program clearly needed a broader definition.

"In our case we call young people those who are still dependent on their families," said Fassil, whose organization works with young men and women up to 30 years old.

NGO staff and volunteer peer educators find these youth hanging out in the streets, small shops, billiard halls, table tennis courts, video houses and traditional drinking spots, trying to fill the hours of the day. Some dropped out of high school, and others were unable to get into a university or technical college. Some are college graduates. Almost all are unemployed.

Bored, hopeless and rejected by their families and communities, these young people often turn to dangerous escape mechanisms. "It's a deadly combination of alcohol, drugs and nothing to do," said AIDSCAP Evaluation Officer Jan Hogle, who helped AIDSCAP staff in Ethiopia conduct in-depth interviews with project managers and peer educators in September 1996.

A knowledge, attitudes and practices survey conducted by one of the AIDSCAP implementing agencies, Marie Stopes International-Ethiopia (MSIE), revealed that about 68 percent of its target population had had more than three sex partners during the previous 12 months.

### Opening the Door

Identifying out-of-school youth and engaging them in HIV/AIDS prevention activities was the first challenge for the seven NGOs. By definition, out-of-school youth could not be found at school or work, so where could they be reached systematically?

"Our entry point was the *kebele* administration," said AIDSCAP/Ethiopia Resident Advisor Beletu Mengistu, explaining that as the local government arm, the *kebele* administration has a list of all the households and household

members registered in its jurisdiction.

*Kebele* leaders helped the projects find out-of-school youth and in many cases provided meeting space for HIV/AIDS prevention activities. In the three *woredas* (districts) of Addis Ababa where MSIE works with out-of-school youth, *kebele* leaders were impressed with the organization's plans and asked how they could do more to help. MSIE formed three Woreda HIV/AIDS Committees of *kebele* leaders, other community representatives and peer educators, which meet regularly to plan and monitor prevention activities.

SYGA also works with another kind of community group, the *Edirs*, which are traditional organizations of 120 to 800 households. Established as an insurance system for funeral ceremony expenses, the *Edirs* have gradually assumed a larger role in community affairs. Through them, SYGA hopes to generate greater support for its activities from parents and other members of the community.

So far only a small number of *Edir* leaders have agreed to work with SYGA, but the ones who have are important allies because community members respect and trust them. "It is a very democratic system, and the leaders are elected by community," Fassil said. "If we open the door to the community system, then I think our objectives will be achieved."

### Their Own Language

SYGA and other NGOs use drama, videos, puppet shows, sports events and other forms of entertainment to attract out-of-school youth to their meetings. "Street dramas are best," a SYGA peer educator said. "You don't need to invite people. They just join in when they see the group forming."

SYGA often performs dramas and puppet shows at the local football grounds during breaks in football games. MSIE works with the Woreda HIV/AIDS Committees to sponsor sports competitions among the *kebeles* to bring youth together. Another organization that received AIDSCAP funding, the Family Guidance Association of

Ethiopia (FGAE), invites youth to its project offices to watch videos and dramas. Sometimes the NGO staff hold writing competitions and award prizes.

These events serve two purposes. They draw in youths and offer them alternatives to other forms of entertainment that may lead to risky behavior. But they also convey HIV/AIDS prevention messages in a way that speaks directly to the audience.

They had never  
imagined that HIV could  
hit so close to home.  
But they knew the  
behavior that had led  
to their friend's death  
was no different  
from their own.

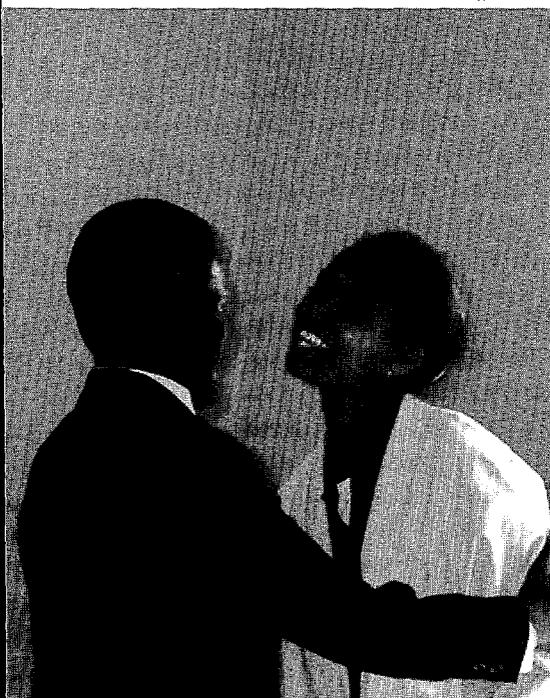
"In the drama, we use their own language and they see their own deeds," explained a SYGA peer educator.

MSIE hired professional artists to produce two dramas, one for staging and another for videotaping. Other projects brought in professionals to train their peer educators at regular intervals. But most of the dramas and puppet shows are created and performed by the peer educators themselves. The Tigray Development Association, which worked with out-of-school youth in the town of Mekele, gave 17 of its peer educators technical training so they could produce their own videos.

## Prevention Options

Performances and other events are only one of the ways the projects reached out-of-school youth. Peer educators and even project staff spent much of their time talking to people one-on-one, advising them on how to prevent HIV transmission and negotiate safer sex with partners. "Whenever we have time, we go to the bars, to the restaurants, everywhere, and we talk about AIDS," Fassil said.

Peter Lamptey/AIDSAP



*Plays like this one performed by the Save Your Generation drama group drew out-of-school youth to project meetings for entertainment, but also taught important lessons about HIV/AIDS prevention.*

In personal conversations, printed educational materials and drama, the projects emphasized giving young people choices and a sense of control. Upbeat messages congratulated youth for adopting healthy sexual behavior.

"We teach every single prevention method equally: abstinence, fidelity and condom use," Fassil said. "We do not advise them to use one or the other. It is up to the person to choose."

This approach makes sense, he added, because different prevention

options may be appropriate for the same person at different stages in his or her life.

Youth participating in MSIE's project liked the idea of different prevention options so much that they named their youth group the "Fleet of Hope Association" after a metaphor that has been used in AIDSCAP programs all over the world. The "Fleet of Hope," which originated in Tanzania, consists of three boats that people can board to escape the "flood" of HIV/AIDS: abstinence, fidelity and condoms.

## Condom Access

Since many out-of-school youth are already sexually active, condoms are an important option. In Ethiopia, where AIDSCAP's social marketing subcontractor, Population Services International (PSI), has sold almost 44 million condoms in three years, inexpensive condoms are available in shops and kiosks throughout the country.

"We have many, many outlets," said Teshome Bongassie, MSIE's AIDS program officer. "In any corner of our catchment area, there are condom outlets."

But peer educators report that young people are often reluctant to buy condoms in public places for fear that someone they know will see them. "The most successful distribution mechanism was that of the PHEs [peer health educators], where youth easily get condoms from their friends without feeling shy," AIDSCAP's Beletu said.

Most of the out-of-school youth projects gave peer educators condoms to distribute. Some gave out condoms for free, while MSIE, GOAL Ethiopia, the Christian Children's Fund of Ethiopia and the Integrated Holistic Approach, Urban Development Project worked with PSI to sell subsidized condoms to youth at a low price.

SYGA tried selling condoms in one district, but found that this approach undermined prevention education efforts because young people looked upon the peer educators as agents of the condom companies. "They said, 'You are

here just for selling condoms. You don't care about us,'" Fassil explained.

Others had more success. FGAE learned just how popular the sales were when the AIDSCAP program ended. Condom supplies ran out, but young people kept asking the peer educators for them. "It was only after discontinuing the selling that we realized there was such a high demand for condoms," an FGAE peer educator said.

Fassil believes that given the wide availability of condoms through the social marketing program, condom skills are even more important than condom supplies. Peer educators teach the youth how to use condoms, how to negotiate their use with partners, and even how to buy them, and give them opportunities to practice these skills. "People did not know how to use condoms properly until we showed them," said a SYGA peer educator.

## Facing Challenges

It takes courage to talk about condoms, sexually transmitted disease (STD) and HIV/AIDS prevention in a culture where open discussion about sex is considered taboo. Young women who served as peer educators reported being harassed and ridiculed. "Some youth tell us that we are girls, and girls should not talk of such things in public," said one young woman who serves as a peer educator.

Others did not want to listen to anyone talk about HIV/AIDS prevention. "Some youth leave the room as soon as they hear the word AIDS," the young woman added.

Parental disapproval was another obstacle. For example, SYGA lost 30 of its first 40 peer educators after training because their parents would not let them continue their work. Since then, the organization has worked with the *Edirs* and *kebeles* to gain parents' support for its HIV/AIDS prevention activities with out-of-school youth.

While some parents objected to their children speaking in public about HIV/AIDS, others believed that the time the young people spent volunteering as peer

educators would be better spent looking for a paying job.

"It was important to give some sort of incentive payment to the peer educators," AIDSCAP's Hogle said. "It didn't matter how much it was, just something to show their parents. If they didn't get incentives, the parents would say, 'You spend all your time on this, what do you have to show for yourself?'"

Some of the NGOs were able to pay the peer educators a small sum or at least cover travel costs, but others were not. Peer educators volunteering for FGAE in Nazareth were resentful because they knew their counterparts in nearby Awassa received 50 Birr (about U.S.\$8) for every day they worked.

But by far the greatest challenge for NGO staff and peer educators was convincing young people that their health was worth protecting. "For them, to value life, to value health, is useless," Fassil said. "They believe they do not have any future, and they do not want to worry about these things."

### Progress and Change

AIDSCAP's program in Ethiopia ended earlier than expected with the conclusion of the U.S. Agency for International Development's (USAID's) HIV/AIDS control project there, so most of the out-of-school projects operated for only two years or less. Yet in that short time, the projects met many of their targets, reaching more than 112,000 young people, training more than 430 peer educators, and selling or distributing over 232,000 condoms.

Although the projects were part of the AIDSCAP program for too short a time to expect significant behavior change, project staff and peer educators believe their efforts have had an impact. As evidence they cite the large numbers of people who ask them questions about HIV/AIDS and STDs, many reports of changed behavior and frequent requests for condoms.

"We have seen that those who were shy to even say condom nowadays carry it in their pocket," a peer educator noted.

"They say, 'I cannot even manage my own girl, so why see different girls, because it is very dangerous,'" MSIE's Teshome said. "They go with one girl only, when they used to have five or six."

The effect on the attitudes and behavior of the peer educators has been the most dramatic. Even those who once thought HIV/AIDS did not exist have become firm believers. Peer educators say they are sticking to one sexual partner and using condoms.

One peer educator says the experience has changed his life. Before joining SYGA, he was addicted to several kinds of drugs and spent time in prison, but now he is a productive, drug-free member of the NGO's drama group.

The skills and experience they gained as peer educators also enabled some youth to find paid employment. One-third of the young people trained by MSIE, for example, have found permanent jobs. SYGA has hired several peer educators to serve on its staff. "I am now self-reliant and can earn my own money, so I am happy," said one, a young woman who was not permitted outside her parents' house until she became a peer educator.

### Maintaining Hope

The NGOs have struggled to continue their HIV/AIDS prevention activities for out-of-school youth since December 1995, when most AIDSCAP funding for projects in Ethiopia ended. FGAE and GOAL have managed to conduct some prevention activities with their own funds, and a few NGOs have found support from other donors. MSIE received support through a USAID-AIDSCAP regional gender training initiative, and SYGA was awarded one of AIDSCAP's short-term Rapid Response Fund grants.

SYGA also received grants from several other organizations. Fassil, who remembers when donors shied away from supporting the group because they thought they were too young and inexperienced to manage grants, believes that SYGA is now in a good position to attract additional funding.

"At the beginning, we did not have a system and we did not know that evaluation is important," he said. "We started seeing it in different ways, thanks to AIDSCAP and different organizations that helped us in building our capacity to run a program."

More established groups such as FGAE and MSIE also benefited from their participation in the AIDSCAP/Ethiopia program, which enabled them to expand their community-based family planning and health programs to address HIV/AIDS. Both groups are determined to continue HIV/AIDS prevention activities, but have not yet identified the necessary funds.

With support from USAID's Regional and Economic Development Services Office for Eastern and Southern Africa (REDSO-ESA) and AIDSCAP's Women's Initiative in 1995 and 1996, MSIE was able to train its peer educators in gender issues so that they can help youth develop negotiating skills that will protect them from HIV infection. "We're creating a forum where young people of both genders can talk openly and honestly about sex and how to protect each other," Teshome said.

MSIE also introduced income-generating activities into the project. Participants earn money by selling tea and soft drinks at the Fleet of Hope Association meeting room, where they also disseminate information about HIV/AIDS. Teshome and Fassil say that a source of income is essential to empowering young people—particularly young women—to refuse unwanted sex and negotiate safer sex.

But for now, just knowing that someone believes their health is important has given many out-of-school youth the incentive to change. "The youth came to understand that there's a hope of living somehow and there is a future," said Teshome. ■

---

*Transcripts of focus group discussions with peer educators and in-depth interviews with project managers conducted in September 1996 are quoted in this article.*

# AIDSCAP Explores Link Between HIV/AIDS Care and Prevention

by Kathleen Henry

---

Experience in communities worldwide suggests that providing HIV/AIDS care and support can help prevent further transmission of the virus. Now an AIDSCAP study will examine how care enhances prevention.

Sean Sprague/Panos Pictures



*A family affected by HIV/AIDS talks to an AIDS counselor in their home in São Paulo, Brazil. A few studies suggest that counseling can play an important role in reducing risk behavior among HIV-positive people.*

Passersby barely notice the large shipping container that stands at the edge of the hospital grounds in a small Tanzanian market town. But others—mostly young men and women—stop and go inside.

Some enter hesitantly, dreading the news that may await them. Others hurry inside, seeking reassurance. For the container serves as the Muheza office of the Tanga AIDS Working Group, a community-based association of health workers that provides HIV pre- and post-test counseling, HIV/AIDS prevention services and continued counseling and support for people living with HIV/AIDS.

These services, offered as part of a project funded by the U.S. Agency for International Development (USAID) in Tanzania's Tanga district, represent one of the new models of care that communities like Muheza have developed in response to a burgeoning AIDS caseload. Outpatient medical care and counseling are available, with referral to the hospital when necessary and home care for those who are too ill to come to the office.

The makeshift office is also one of the sites for a unique research study, one of the first to assess how providing such care for people living with HIV/AIDS affects their sexual behavior. "People have talked about the linkages between care and prevention, but nobody has really examined those linkages," said Dr. Joan MacNeil, who designed the study.

Out of this research and service delivery experience at Tanga will come a greater understanding of two of the most important questions facing policymakers and program managers in the second decade of the epidemic: how to help people who are infected reduce the spread of the virus to others and how to provide more affordable and effective care and support to people living with HIV/AIDS.

### Care in Communities

Since the beginning of the epidemic, international HIV/AIDS programs have addressed care and prevention sepa-

rately. Faced with limited resources and no effective, affordable treatment against the virus, most donors and many nongovernmental organizations (NGOs) in developing countries opted to support HIV prevention efforts, leaving AIDS care and support to government- and church-funded health services.

But the demands the epidemic makes on these services has stretched

■

"People have talked about  
the linkages between care  
and prevention, but nobody  
has really examined  
those linkages."

■

them almost to the breaking point. In a number of African countries, for example, half of all hospital patients are infected with HIV. "Most hospitals are overburdened in high-prevalence countries," said Dr. MacNeil, who is associate director for behavioral research at the AIDS Control and Prevention (AIDSCAP) Project. "They just can't cope."

Government spending on AIDS care in some of these countries equals 50 percent or more of the annual health care budget, and costs will continue to soar as more and more people develop AIDS symptoms and related illnesses.

Concerns about spiralling costs are one of the driving forces behind the move to community-based care. Another is concern for those who are infected: caregivers recognized early on that people living with HIV/AIDS do not always need to be hospitalized when they fall ill and that many episodes of illness can be managed at home. Grassroots organizations responded by developing services in communities, including basic medical care, counseling,

and training and support for family members and other caregivers.

Questions remain about the most cost-effective ways to provide these services in different settings. The promising models that have emerged—often from the communities themselves—include outpatient clinics, residential community centers, hospices and home-based care.

Although its mandate is to strengthen capacity in HIV/AIDS prevention, the AIDSCAP Project had an opportunity to help several organizations provide such community-based care and support services through a small grant program. And in the USAID-funded Tanzania AIDS Program (TAP) managed by AIDSCAP, prevention and care have been integrated from the beginning.

### Overcoming Fear

In Haiti, where an estimated 12,000 people had developed AIDS by 1995, AIDSCAP grants enabled two hospitals to extend HIV/AIDS care into the communities they serve. Hospital staff provided medical care, counseling and prevention education at outpatient clinics and in patients' homes. Counselors helped individuals and families cope with the emotional and practical challenges of living with HIV/AIDS. The projects even offered small loans to help unemployed HIV-positive people earn income and allow children orphaned by AIDS to stay in school.

The AIDSCAP grants were greeted enthusiastically in Haiti. Dr. Eddy Génécé, who served as resident advisor of the AIDSCAP program until it ended in 1996, said that many organizations had been requesting the program's support for care projects. Within a month after he announced that the grants were available, Dr. Génécé received eight proposals.

One of the three Haitian recipients, a community-based hospital affiliated with the Baptist Church called Hôpital de Fermathe, serves a population of about 100,000 people in the mountains south of Port-au-Prince. In 1994,

Fermathe's staff found that 49 of the last 100 HIV tests performed at the hospital had been positive.

In the isolated rural communities served by the hospital, HIV/AIDS was considered the result of a supernatural curse, and people who contracted the disease were shunned. Hospital staff recognized they needed to go out into the communities to help people living with HIV/AIDS and to teach their neighbors how to care for them.

With AIDSCAP support, Fermathe staff offered HIV care and counseling at the hospital's four satellite clinics and through a mobile health clinic. They also worked through the churches, ask-

■

**Separating  
care and prevention  
may even undermine  
prevention efforts.**

■

ing each community to identify a caregiver to receive training. These caregivers—usually ministers or other religious leaders—learned how to support people living with HIV/AIDS, advise families on caring for them, and refer people to other support services.

Convincing religious leaders to play such an active role in the program was one of the hospital's most remarkable achievements, according to Dr. Génécé. He explained that before the hospital began discussing HIV/AIDS with community leaders, many clergy members stood in harsh judgment of those who had contracted HIV/AIDS.

"In several areas the religious leaders refused to do funeral services for someone who had died of AIDS," said Dr. Génécé, who now directs a Haitian NGO devoted to HIV/AIDS prevention and care, *Promoteurs*

*l'Objectif ZeroSIDA (POZ).*

Eighty outreach educators from the hospital's community health program reinforced the caregivers' messages of prevention and compassion. They also distributed condoms and a Creole-language brochure about preventing HIV/AIDS and other STDs.

Marie-Thérèse Racine, a nurse and counselor at Hôpital de Fermathe, believes that community members are beginning to change their sexual behavior. She knows that as a result of the hospital's program, many people have changed their attitudes toward people living with HIV/AIDS. "Gradually, with sensitization, they began to understand, to ask questions," she said.

These education efforts helped community members understand that HIV/AIDS is not the result of a supernatural curse. Acceptance of HIV/AIDS as an illness led to less stigmatization of people with HIV/AIDS and greater willingness to speak openly about preventing transmission of the virus.

People's ability to talk about HIV/AIDS in public—even in the most unlikely places—is a sign of how much the program accomplished in a short time, Dr. Génécé noted. As evidence he cites a meeting he attended in a church, where community members discussed their experiences with the 16-month project.

"They said that at the very beginning they couldn't even say the word condom in the church because the pastor didn't allow it," he said. "And now that has changed."

#### **Hand in Hand**

Unlike most donor-supported efforts at the time, the Tanzania AIDS Project (TAP) included care and support when it began in 1994. AIDSCAP Resident Advisor Penina Ochola noted that this decision had as much to do with the structure and philosophy of the program as it did with the desperate need for such assistance in a country where more than 120,000 people had already developed AIDS.

"We built on what was already there

in the community," Ochola said.

What they found were health providers and NGO personnel grappling with the twin problems of care and prevention. TAP was designed to help NGOs and other grassroots organizations coordinate these efforts and strengthen their ability to manage HIV/AIDS programs.

In the nine areas of the country most affected by the epidemic, TAP established "clusters" of NGOs that work together on community-based prevention and care projects directed by a "lead" NGO.

Most clusters have an information center where they offer HIV/AIDS counseling, support and referrals to nearby services for medical care. In the town of Tanga, for example, the information center is in the same building as the office of the district AIDS coordinator, right beside the district hospital.

Medical treatment, care and prevention are closely integrated because the Tanga cluster is managed by the members of the local health professionals' association, the Tanga AIDS Working Group. The group's peer education and other outreach efforts are complemented by the counseling, which gives staff members opportunities to discuss prevention with those who are already HIV-positive.

"In caring for and involving those affected, you're also addressing the issue of helping them avoid infecting others," Ochola said.

Most people served by the cluster go to the Tanga information center for information, counseling and support. But as in Muheza, where the Tanga AIDS Working Group has a satellite office, home care is available for those who are too ill to make the trip.

The public health nurses who provide home care do all they can to meet the physical, emotional and psychological needs of patients and families struggling with serious—sometimes terminal—illness. On any given day they might administer intravenous fluids, advise family members about basic

*A Ugandan mobile health team visits an AIDS patient at home. Home care is one of the options to hospitalization communities have developed in response to a burgeoning AIDS caseload.*

nutrition and safety precautions, and provide grief counseling.

About 50 patients receive home care. Since the working group has only one vehicle, the nurses usually walk or ride bicycles—often for miles—to the patients' homes. They make these trips on weekends or in the afternoons or evenings after putting in a full day at the hospital or information center.

"They are very, very dedicated," Dr. MacNeil said. "One of the nurses was talking about a patient she was visiting daily."

This kind of caring—in both senses of the word—seems to make people more responsive to prevention messages, according to Ochola. "Care and prevention have to walk hand in hand," she said.

### The Tanga Study

As millions of HIV-positive people develop AIDS, the line between prevention and care is disappearing in communities throughout the world.

"We know that it's almost impossible to separate the two at the practical level, especially in higher-prevalence countries," Dr. MacNeil said.

In fact, she added, separating care and prevention may even undermine prevention efforts. "If people living with HIV/AIDS feel abandoned by care services, they are less likely to acknowledge their status or to be motivated to protect others."

Experiences like those of the Hôpital de Fermathe and the Tanga AIDS Working Group suggest that HIV/AIDS care and prevention are complementary, but little is known about how care actually influences prevention. A few studies, mainly from developed countries, suggest that care and support in the form of counseling can play an important role in reducing risk behavior among people



Sean Sprague/Panos Pictures

living with HIV/AIDS.

AIDSCAP's study in the Tanga district is designed to detect differences in risk reduction among HIV-positive people who receive enhanced support and those who receive post-test counseling only. Members of the experimental group will participate in regular counseling sessions and may request a home visit.

These home visits are for support rather than medical care, Dr. MacNeil explained. "During a visit, a counselor will talk to family members about what it means to be HIV-positive and how they can work together."

All participants will receive condoms, and no one will be refused counseling or other support services. "If people in the control group drop in to any of the centers, of course they will get services," Dr. MacNeil said, "but it's not a systematic effort to talk on an ongoing basis about their problems."

Principal investigator Dr. Gad Kilonzo started recruiting participants at three sites in the Tanga district in November 1996. People are asked to enroll voluntarily in the study after the second of two post-test counseling sessions. Approximately 200 people will be enrolled.

Members of both groups are inter-

viewed at enrollment, after three months and at the end of the six-month study period. Researchers collect information about illnesses, hospital and clinic visits, episodes of sexually transmitted disease and, for women, pregnancy. They ask about risk behavior, condom use and other prevention strategies, discussing HIV with partners, and relationship histories. Participants also discuss their thoughts about their condition, the reactions of their families and communities, and the impact of their HIV status on decisions about having more children.

All of this information is expected to shed light on how people make decisions during the first months after they learn that they are HIV-positive and on the kinds of support that encourage them to adopt preventive behaviors. The findings, which will be available by the end of 1997, will be shared with policymakers, donors, program managers and health care providers.

"The results can be used to develop strategies for supporting behavior change over time among people living with HIV/AIDS," Dr. MacNeil said. "This is one small study, but it will give us a better understanding of one of the most critical issues in this second decade of the pandemic." ■

# Opinion

## Integrated Reproductive Health Services: Where Do We Go From Here?

by Mary Lyn Field and Gina Dallabetta

---

**To fulfill the promise of the integrated approach to reproductive health, we must move beyond rhetoric to practical operational research and cost-effectiveness studies.**

Mary O'Grady/AIDSCAP



*A woman comes to the Chitwan State Clinic in the Nepalese city of Bharatpur seeking contraceptives. While discussing her family planning needs with a provider, she mentions that she has been experiencing pain in her lower abdomen. The provider carefully explains that this symptom could be a sign of a sexually transmitted disease (STD) and suggests that the woman see the clinic's physician.*

*The doctor talks to the woman about her symptoms, does a pelvic examination and asks her some questions to assess her risk of sexually transmitted infection. Then he tells the woman that she probably has an STD and explains the importance of taking all the prescribed medicine, even if she feels better after a few days. He advises the woman on how to prevent further infection, and the assisting staff nurse gives her a wallet of condoms and a referral card for her husband. The nurse also provides tips on how to convince the husband to seek treatment.*

*The nurse asks the woman to stop in the clinic's Health Education Room on her way out. There she meets with a woman health educator who demonstrates how to use a condom and gives her a simple brochure about STDs and HIV/AIDS. Before leaving the clinic, the woman sits for a few minutes to watch a short, entertaining videodrama about condom use and HIV/AIDS prevention.*

---

*Nepali women wait to see the doctor on a Saturday afternoon at the reproductive health field clinic organized by FPAN and the nongovernmental organization General Welfare Pratisthan in the village of Malekhu.*

---

This clinic run by the Family Planning Association of Nepal (FPAN) exemplifies a global trend in women's health care: comprehensive reproductive health care that integrates STD prevention and treatment into long-established and better-funded family planning and maternal-child health (MCH) services.

The logic behind integrated services is straightforward. Women who defer treatment for a suspected STD rather than risk the social stigma of using an STD clinic would probably feel more comfortable seeking care at a family planning or MCH clinic that they already patronize. And because STDs can affect not only a woman's health but also contraceptive efficacy, fertility and neonatal outcome, the incorporation of STD diagnosis and treatment into family planning and MCH services could mean better contraceptive and obstetrical results. Such "one-stop" shopping also offers the potential for cost savings and more efficient use of often-scarce resources.

Support for integrated reproductive health services has grown worldwide. The concept was strongly endorsed at the 1994 International Conference on Population and Development in Cairo. Since then, numerous international health and development organizations have called for integration of STD, HIV/AIDS, family planning and MCH programs.

Yet despite such support, the promise of integrated reproductive health services is far from fulfilled. Clinics like the one described above are still rare. With a few exceptions, attempts to integrate STD prevention and treatment into family planning and MCH services have been half-hearted or technically incorrect.

Why haven't we seen more progress in integration—and what will it take to move forward? Perhaps a reality check is the way to start. First we must recognize that the integration ideal that inspires conference declarations and policy papers may be too ambitious for resource-poor health care systems.

Equally important are the long-overdue evaluation studies and operations research that can confirm whether integration is feasible and cost-effective in different settings. Once this solid foundation of knowledge has been laid, a final problem—the lack of widely recognized program and technical guidelines—can be tackled.

children, STD prevention and treatment are receiving new attention. The value of effective STD services is reaffirmed with each new research effort. Recent research in Malawi showed that treating men for urethritis also reduces the concentrations of HIV found in their semen, making them less likely to transmit the virus to their partners.<sup>1</sup> And most

Ron Giling/Panos Pictures



*A family planning worker demonstrates condom use to a young mother in Indonesia. Negative attitudes about condoms among many clients and staff are one of the obstacles to integrating HIV prevention and STD services into family planning programs.*

### A Critical Need

Compared to family planning and MCH, STD programs have historically been underfunded and poorly resourced. With the advent of the HIV/AIDS epidemic, that second-class status persisted as better-funded HIV prevention programs appeared in response to a fast-moving, lethal epidemic.

Yet as evidence mounts that certain sexually transmitted infections increase susceptibility to HIV as much as nine-fold and that untreated STDs have severe consequences in women and

convincingly, a community-based trial in the Mwanza district of Tanzania found that using the syndromic approach to treat STDs reduced HIV incidence in the study population by a stunning 42 percent.<sup>2</sup>

As awareness of the importance of STD prevention to HIV/AIDS control grows, so does a renewed appreciation of the threat that STDs themselves pose to women. In women 15 to 44 years of age, STDs are second only to maternal morbidity and mortality as a cause of healthy years of life lost. And in many



FPAN

*The staff nurse at FPAN's integrated reproductive health clinic in Bharatpur uses a counseling flip chart to discuss STDs with a client.*

developing countries untreated STDs are the leading cause of infertility in women—a devastating emotional and social blow in communities where motherhood defines a woman's identity.

STDs in women often go untreated because the women have no symptoms. Even when they do have symptoms, many women do not seek treatment because they do not recognize the symptoms or they fear the stigma of attending an STD clinic.

Failure to treat an STD has debilitating—sometimes even fatal—consequences. For example, a frequent complication of untreated gonorrhea or chlamydial infection in women—pelvic inflammatory disease (PID)—can lead to ectopic pregnancy, with subsequent maternal death or chronic pelvic pain and pelvic infections. PID also accounts for much of the infertility that occurs in the developing world: an estimated 66 percent in African women and 34 percent in Asian women.

The impact of STDs on pregnancy outcomes and children's health is equally severe. Untreated STDs in pregnant women can result in fetal loss, prematurity and low birth weight. For example, about 40 percent of pregnancies in mothers infected with syphilis end in spontaneous abortion, stillbirth

or perinatal death. Maternal infections can also be passed on to unborn children, causing congenital syphilis, ophthalmia neonatorum (eye infections that can lead to blindness without treatment) and chlamydial pneumonia in newborns.

### **Barriers to Integration**

Given the terrible costs of untreated STDs, it's little wonder that many public health specialists hope that integrated reproductive health services will bring long overdue attention to STD prevention and treatment. Unfortunately, support for the concept of integration has greatly outpaced efforts to address the technical, financial, programmatic and psychological constraints that impede its implementation.

Many clinics do not have the resources to provide full-scale STD services to their clients. For example, many do not have the staff to handle the increased responsibilities or the funding to hire more personnel. Clinic staff often are not trained to treat STDs, and programs may not be able to afford the ongoing training and supervision required to ensure quality services. Space for examination rooms and private counseling sessions is not always available, and STD drugs may be too expen-

sive or difficult to procure. Community outreach is important to a program's success, but requires funds for developing outreach materials as well as staff time.

Other barriers to integrating services are cultural and psychological, sometimes involving deeply ingrained negative attitudes about STDs and those who suffer from them. Family planning and MCH program managers are not immune to the stigmatizing attitudes of the society around them and sometimes fear “contamination” of their clinics' reputations and loss of clientele if they offer STD services. Many family planning providers are reluctant to promote the use of condoms, which they consider an unreliable, ineffective and unpopular method of contraception. And some professional staff trained in standard diagnosis and treatment practices may also feel uncomfortable with the syndromic management approach to STD management that is recommended for settings where laboratory testing is slow, too expensive or unavailable.

Even when programs do seek to integrate their services, guidance about what integration is and how it should “look” are largely absent in the public health literature. Without an operational definition of integration, many programs struggle to respond to entreaties to integrate, unsure of how to proceed, and misunderstand or misapply important concepts and methodologies.

One example is the use of risk assessment for STD case finding. Algorithms used in the syndromic management of vaginal discharge now incorporate a risk assessment tool to distinguish symptomatic women who are likely to have a cervical infection from those with vaginal infections. Some newly integrated programs have adopted this risk assess-

ment as a way to identify STDs in women who have no symptoms, even though studies do not validate such use of this tool. Ultimately, this misappropriation of the methodology could unfairly discredit the syndromic approach.

Other consequences of the lack of systematic procedures for integration involve sins of omission rather than commission—but with equally serious consequences. Many family planning and MCH clinics that claim to have integrated programs concentrate on HIV prevention education but do not include STD information or screening histories. This is often true of community-based HIV prevention programs as well. As a result, it is not unusual for people to have a better understanding of HIV than STDs, even though their risk of acquiring an STD outweighs their risk of HIV infection.

Many “integrated” programs—and most antenatal clinics in the developing world—also neglect to screen for syphilis, even though the serological test for syphilis is simple to perform and both the test and the treatment are inexpensive. Experience in Jamaica has shown that clinic staff with little or no laboratory experience can be trained to perform syphilis blood tests with high levels of accuracy.<sup>3</sup>

Screening for syphilis is particularly important in antenatal clinics because untreated maternal syphilis can lead to transmission of the infection from mother to child, which can cause fetal loss, perinatal and infant death, and long-term childhood illness. All of these adverse pregnancy outcomes can be prevented through routine serological screening and early treatment of both partners.

### Moving Forward

It's time to recognize that integration of reproductive health services is not an all-or-nothing endeavor. Given the wide-ranging economic, technical, cultural and social constraints, small steps toward integration are both legitimate and valuable. As long as the methodology is sound, MCH and family planning

programs can incorporate aspects of STD prevention and treatment into the work they already do, building familiarity with and confidence in the integrated approach.

For example, many family planning clinics could assess women for STD symptoms and educate clients about STD transmission, prevention, complications and treatment. Setting up referral networks for women with STD symptoms when a clinic is not prepared to offer treatment is more of a challenge, but certainly not impossible. At a minimum, there should be routine syphilis screening of women at all antenatal clinics and prevention counseling and referral at family planning and MCH sites.

Offering these basic services will require behavior change on the part of many—but not all—providers. Indeed, providers in a Kenyan family planning clinic serving a high-risk population asked for training in STD management because patients had requested treatment for STD symptoms. But many providers need training not only to increase their technical capacity to deal with STDs but also to change their attitudes toward patients with these diseases.

It's also time to invest in operations research to answer a number of important questions. For example, policymakers and program managers need to know how much it costs to add STD prevention and treatment to family planning and MCH services, how such integration affects clients' use of contraceptives (including dual method use), and whether it improves the quality of all reproductive health services. Research is needed to identify the best approaches to STD prevention and treatment education in clinics and the optimal mix and level of STD services in different settings. And in settings where full integration is not possible, program managers need to determine the most viable options for referrals.

Cost-effectiveness studies are essential to determine whether integration of reproductive health services is advisable in specific settings. In areas where STD

prevalence is low, for example, the benefits of integrating services might not offset the costs. On the other hand, when STDs affect a substantial proportion of the population served by a family planning or MCH clinic, the cost of failing to integrate might be even higher than the time and expense required to train staff and provide additional services.

These are hardly abstract research questions, and finding answers to them will enable program managers to make sound decisions about when, if and how to integrate services. They will also provide operational definitions and procedures to make integration more effective and less difficult to accomplish.

Integration of services is one route to improving women's reproductive health, not an end in itself. It's not easy to develop programs that are scientifically valid, responsive to patients' needs, and affordable and feasible in an era of ever-scarcer resources. Taking the slow but steady road toward integration may not eliminate all the obstacles, but the destination—an effective and comprehensive approach to reproductive health services—will enhance the health of women, children and communities. ■

---

### References

1. Cohen M, I Hoffman, R Royce, et al. 1997. Treatment of urethritis reduces the concentration of HIV-1 in semen: implications for prevention of transmission of HIV-1. *The Lancet*. In press.
2. Grosskurth H, F Mosha, J Todd, et al. 1995. Impact of improved treatment of sexually transmitted diseases on HIV infection in rural Tanzania: randomized controlled trial. *The Lancet* 346:530-36.
3. Behets F, L Bennett, A Brathwaite, et al. 1997. Decentralization of syphilis screening for prompt treatment and improved contact tracing in Jamaican public clinics. *American Journal of Public Health*. In press.

---

Mary Lyn Field, MSN, FNP, is the senior program officer in AIDSCAP's STD Unit. Gina Dallabetta, M.D., is the project's director for technical support.

# Taking New Skills Home:

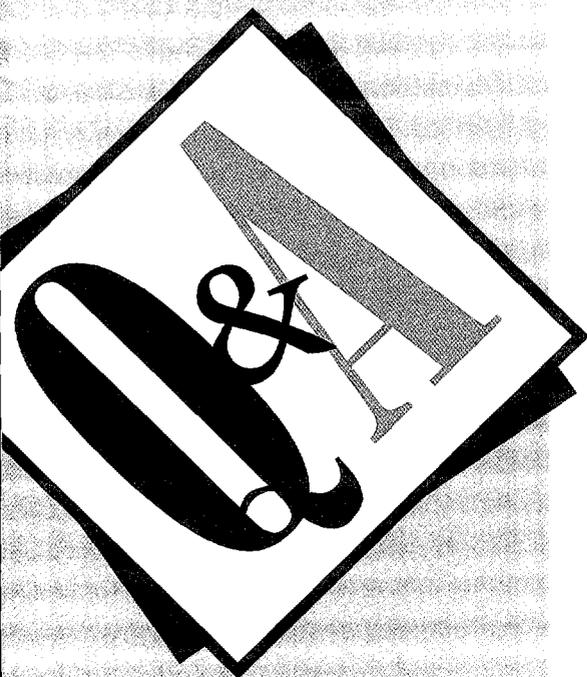
## Regional Training Program Builds HIV/AIDS Capacity in Asia

Although HIV/AIDS has been a deadly threat throughout Asia for more than a decade, key players in health, policy, communication and journalism have not always had access to the information and tools they need to design and manage effective prevention programs or to report knowledgeably on the disease through the mass media. With seroprevalence rates rising throughout the continent, ongoing training is essential to the success and sustainability of efforts to prevent this complex, ever-changing epidemic.

From 1993 to 1996, the AIDS Control and Prevention (AIDSCAP) Project's pioneering Regional AIDS Training and Education (RATE) Program offered such skill-building opportunities to 111 professionals from Thailand, Cambodia, Laos, Nepal, India, Bangladesh, the Philippines, Mongolia, Sri Lanka, Indonesia and the South Pacific islands. Training was organized around four general themes: behavior change communication, sexually transmitted disease (STD) management, policy development in HIV/AIDS prevention (including workshops for journalists) and training of trainers.

To build the capacity of regional institutions to sustain this important training function after AIDSCAP's funding from the U.S. Agency for International Development (USAID) ended, centers of excellence were created at three Thai universities: Dhurakijpundit University's Asia-Pacific Development Communication Center (ADCC) for training and behavior change communication, Mahidol University's Institute for Population and Social Research for policy development and journalism training, and the Women's Studies Center at Chiang Mai University for gender issues.

*AIDScaptions* asked Dr. Chalintorn Burian, who directed the RATE Program from AIDSCAP's Asia Regional Office in Bangkok, Thailand, to reflect on the program's success and share her thoughts on lessons learned in sustainability and capacity building.



### **How did the RATE Program begin?**

When I joined AIDSCAP in June 1993, USAID's Asia Near East Bureau had just approved funding to develop human resources for AIDS prevention in the field. AIDSCAP conducted an assessment with AIDSCAP resident advisors and other health leaders in Asia to determine the region's training needs.

### **What were some of the concerns in the design stage of the program?**

From the very beginning, we looked at the issue of sustainability. We knew in 1993 that there were only three years of funding left for AIDSCAP, but that it would take longer for our training efforts to have a real effect. This led us to the idea of building the regional center of excellence in training and communication skills development at ADCC, which continues to conduct training workshops created by the AIDSCAP effort, and the two other centers at Mahidol and Chiang Mai universities.

### **Did you follow a design model?**

Actually, this approach in capacity building is unique in the field of AIDS prevention and in public health generally. I got the idea from the private sector, when I worked as the human resource development director for the Petroleum Institute of Thailand. The centers of excellence concept is widespread throughout industry as an effective way to build both individual and institutional skills, and it seemed to us that it would also work well in health training.

### **In what other ways did your experience in human resource development influence RATE's design and start-up?**

It helped me identify three key issues. First, what needs to change? Second, what are the skills, knowledge and attitudes we need to build? And third, can these be taken back and applied in other countries? In many ways, this third question became one of the biggest and

most interesting challenges throughout the three years of RATE's existence, as well as a major focus for the evaluation we conducted as AIDSCAP's role ended.

### **Why was that?**

Connecting the right skills, knowledge and attitudes with the people who can best use them is only the first step in training. We worked closely with USAID missions, AIDSCAP country offices and national health agencies to recruit bright and energetic participants from across Asia who weren't just looking for a vacation abroad, who would take responsibility for applying what they learned back home. But in the beginning we sometimes found that even some of our most motivated graduates couldn't fully implement their new skills when they returned and we needed to figure out what to do about it.

### **What was the problem?**

There were many possible reasons. The home agency or supervisor might not be convinced of the need to put resources into HIV prevention, or might not be supportive for other reasons. Some of the techniques that RATE trainers seek to pass on to their peers back home may be conceptually difficult to accept. It could be a working environment problem, a management problem, a funding problem, a problem involving cultural norms, a staffing problem.

### **Can you give us some examples of these constraints?**

One Cambodian respondent to our evaluation questionnaire complained of limited staff to conduct BCC materials development. An Indonesia health reporter told us that her editor said she already "writes too much about AIDS." Others reported resistance from fellow medical personnel to adopting STD syndromic management guidelines.

### **How did RATE deal with such a broad range of issues?**

The solution was always multifaceted and ongoing. First, we had to refine our

selection process by working directly with supervisors, making sure that they saw value in this training and intended to fully support their returning graduates. Such collaboration, combined with information from questionnaires filled out by participants before training began, helped us assess the needs of a particular organization so we could tailor the curriculum to those needs. Second, we stayed in touch with our participants long after their initial training experience ended, follow-up that became an excellent source of feedback for us.

Kari Hartwig/AIDSCAP



**Dr. Chalintorn Burian**

### **How was this follow-up conducted?**

It happened both in the field and in subsequent RATE training sessions. Whenever possible, I or other AIDSCAP staff visited graduates at their home agency within the first few months after training to observe them at work and often help them on site. Those visits gave us an opportunity to see how applicable and adaptable the curriculum had been for that individual and how to improve the training experience in the future.

We also invited many participants back to Thailand to continue their training, and by that stage many had a clear idea of what they needed that they



*A graduate of an AIDSCAP training-of-trainers course in Bangkok trains peer educators to spread the word about HIV/AIDS prevention in the slums of Madras, India.*

AIDSCAP/ARO

didn't get the first time around. We paid lots of attention to that feedback.

**Have you made any unexpected discoveries as you do these assessments?**

Well, we have discovered a syndrome I call "separation-from-your-mentor" illness that strikes some of our graduates, especially the ones who haven't stayed in touch. Some find that returning to their home environment can overwhelm their training, especially if they're the only ones around who are dealing with new technology or have attained new technical skills. They end up reverting to old ways of looking at and doing things. Follow-up and ongoing support are the best possible cure!

**Could you give an example of new perspectives RATE participants gain through skill building?**

Here's an important one: understanding the concept of behavior change communication (BCC), as opposed to

the more familiar information, education and communication (IEC). Graduating from IEC to BCC by learning about theories of behavior change is a big conceptual leap that really advances their programming skills. In our BCC courses we expose participants to a behavior change framework developed by AIDSCAP over and over again through multiple exercises, using many of AIDSCAP's excellent new BCC handbooks. Mastering these strategies is a very exciting intellectual as well as professional breakthrough.

**How was AIDSCAP's recent evaluation of the RATE Program conducted?**

Both quantitative and qualitative techniques were used to gather information, primarily through questionnaires sent to RATE alumni, in-depth interviews and follow-up workshops held in each country. Data and assessment information gathered throughout RATE's three years of life were also helpful.

**What were some of the major findings?**

First, most RATE graduates—92 percent—said that they felt the courses they took met their needs in STD/HIV prevention work. In interviews participants praised a wide variety of course features, including working as a group, the careful planning devoted to each course, specific skill-building exercises and field trips.

On the quantitative side, the evaluation sought to find out whether participants had been able to conduct at least one HIV prevention program or related training after attending a RATE course; 76 percent answered yes. The remaining 24 percent responded that they were able to apply newly gained knowledge, skills and management competencies to their jobs.

**Have RATE graduates advanced in their professions as a result of their training?**

Many respondents—again, 92 percent—said their jobs had expanded to include a wider variety of HIV prevention activities. One out of three reported that they had been promoted since their training, with 27 percent of that group attributing promotions in part to their RATE experience. Many also cited increased self-confidence, job performance and personal effectiveness as further benefits of their training experience.

**How are RATE graduates "redis-tributing" their new wealth of skills and knowledge when they return home?**

Of course, the programs for which they work in their home country benefit from their new expertise. But one exciting development that we didn't really anticipate, something we learned in follow-up assessments and in doing the final program evaluation, is that their skills and confidence have so impressed their colleagues back home that many have been asked to give lectures and to start training other people. Now we're recommending that participants also

receive training in presentation and training skills to satisfy this demand. A shorter training-of-trainers course would be very effective for this.

### Is this demand for trainers primarily for BCC skill development?

Not necessarily. We're finding that RATE participants of all kinds are being asked to share their new knowledge with their colleagues at home. For instance, an Indonesian reporter who attended the "Facing the Facts" workshop for journalists told us that other reporters wanted him to organize a similar workshop back home, so we asked him to stay for two extra days for a cram course on presentation skills and curriculum development.

### Did he make use of his new skills?

He created a very successful workshop for journalists in Yogyakarta and even organized an award for the best writing on HIV/AIDS, just as the RATE Program did. He has also given lectures on AIDS to university students. This man has far exceeded what RATE might have expected of him, and now we see the real potential for much more of that among our graduates.

### How else can that potential be tapped?

We're also recommending that course work be developed in all of the languages of countries where participants come from. Regional RATE training in Thailand has been conducted in English, but we can extend our work by bringing the workshops right into the country, using graduates from the regional courses as resource people, trainers and facilitators. This approach would double the benefits of our regional training by strengthening what our regional graduates have learned through hands-on training of others, but also by helping to create critical mass in all the countries where we work.

### What is critical mass?

This is one of my favorite terms in hu-



Indian journalists trained by AIDSCAP conduct a workshop on HIV/AIDS reporting for journalists in their home state of Tamil Nadu.

AIDSCAP/ARO

man resource development. It means having enough people in one place receiving training, mastering skills and gaining new perspectives that they're able to reinforce each other and build networks. It's always been a goal for RATE, but hasn't always been easy to achieve. For instance, we make a point of inviting two people from each country to each training session to support each other back home, but since they often live in different cities, they don't necessarily continue to communicate. In-country training could create critical mass much more quickly.

### Does this mean, though, that the centers of excellence in Thailand will become less important?

Not at all. Training at the centers offers important educational dimensions not available at the country level. It helps participants develop a regional perspective and offers field study in Thailand, where both the AIDS epidemic and responses to it are more advanced than in

other Asian countries. In fact, in-country training is assisted by the centers of excellence.

### Have any networks emerged yet?

RATE alumni have in fact set up trainers' networks in India, Laos, Thailand, Cambodia, Nepal, Indonesia and the Philippines. AIDSCAP is supporting them by sending them HIV/STD training materials and manuals and copies of relevant studies in HIV intervention. I'm sure the number and strength of these networks will increase as more in-country training is developed. ■

---

*Chalintorn Burian, Ph.D., a former staff member of the Program for Appropriate Technology in Health, an AIDSCAP subcontractor, was the training officer in AIDSCAP's Asia Regional Office in Bangkok, Thailand. She now serves as Southeast Asia regional director for the Institute of International Education.*

# Women's Forum



## Inclusive Prevention Efforts Fight Stigma in Rural India

by Margaret J. Dadian

---

**To support a group of stigmatized women sex workers vulnerable to HIV, a rural prevention project reaches out to inform and empower their neighbors as well.**

Every December, on the day after the full moon rises, an age-old ceremony takes place in Soundatti, a town in south India. At the famous shrine of the Hindu goddess Yellamma, people from all over the Belgaum region assemble to mark the traditional date of initiation for the *devadasis*, women who devote their lives to worship of the goddess and to maintaining her temples.

Many of these women were tiny girls when they became *devadasis*, "dedicated" to the sect by poverty-stricken parents unable to pay their future dowries and hopeful that a pleased goddess would make the next pregnancy a boy. Tradition has for centuries locked *devadasis* into a proscribed and highly stigmatized social role. Forbidden to marry or work outside the temple, they have spent their lives tending the shrines and decorating altars, singing and dancing, telling devotional stories and col-

lecting coins from worshippers to support themselves and their religious work. Historical records show that some also served the royal family as courtesans.

"As donations slowly dwindled, this form of concubinage evolved over many years into socially sanctioned prostitution," said public health specialist Sudha Sivaram. "Over the years, the caste of women who were *devadasis* by profession were forced by social, legal and, most importantly, economic circumstances to resort to sex work as their source of income."

Sivaram knows the *devadasis* and their plight well. From 1994 to 1996 she worked with U.S.-based PLAN International and its regional partner, MYRADA (the Mysore Resettlement and Development Agency), as manager of an HIV/AIDS prevention project funded by the AIDS Control and Prevention (AIDSCAP) Project's grant

program for private voluntary organizations.

MYRADA, long active in rural Belgaum, had already established close ties with the *devadasis* by creating economic self-help groups to give them an alternative to sex work. The discovery in 1993 that more than 9 percent of these women were infected with HIV prompted PLAN/MYRADA's original proposal to target *devadasis* and other sex workers. But the project soon took on a much broader scope.

"MYRADA's extensive experience in rural development in an integrated manner, and our knowledge of the social stigma that is attached to HIV infection and AIDS, helped us soon realize that it would be a mistake to direct prevention messages to *devadasis* alone after learning that people in the area were already accusing them of spreading AIDS," said Sivaram. "It would only brand them further as outcasts and give the rest of the community the false impression that AIDS prevention isn't an issue for everyone."

What ultimately evolved during Belgaum's AIDS/STD Awareness Prevention and Control Programme was an extraordinarily broad-based campaign that reached into every sector of this rural district and involved many thousands of its residents as outreach educators, condom sellers, street performers, youth leaders, health promoters and much more. Project staff—almost all of whom were born in the area—perceived early on how to tap the energies of community groups and to motivate the activism they knew had long been part of Belgaum's civic culture. In two short years, they created an unusually successful and sustainable grassroots project that confirms the value of using and building local capacities to design and lead HIV/AIDS prevention efforts.

### Raising Awareness

At the beginning of the project, PLAN/MYRADA staff conducted group discussions to assess the general awareness of HIV/AIDS and other sexually trans-



*Devadasis recount their experiences.*

Kari Hartwig/AIDS CAP

mitted diseases (STDs) among the population. The results were discouraging: A majority of the women had never heard of HIV/AIDS, and few of the respondents—female or male—who did know about it also knew how to prevent it. Many held misconceptions about the disease: that it can be caused by mosquito bites or casual contact, that chewing betel leaves puts one at risk, that barbers spread it on their scissors. The discussions also revealed that many people did not see HIV/AIDS as an immediate threat, given other pressing survival concerns such as employment, food and other better-known diseases.

Raising awareness among all adults and young people of reproductive age in the project's four targeted administrative divisions thus became a primary goal. The scale was ambitious: 525 villages of about a million inhabitants. To reach as many as possible within the project's relatively short time span, PLAN/MYRADA staff conducted an informal survey of community groups—student and youth clubs, professional associations, women's groups, the truck drivers' unions—to get a sense of the various organizational routes through which they could recruit and train their goal of 1,000 outreach educators and conduct AIDS awareness activities.

MYRADA's long history of work in regional development, extensive community contacts and excellent rapport with the district government and health agencies made the task much easier. "MYRADA has worked in the region for 25 years and is very well respected," said Dr. Thomas Philip, AIDS CAP's resident advisor in India. "Their grassroots relationships with the people and organizations the project wanted to reach meant much quicker access and thus a faster start-up."

With training modules created for specific groups, staff eventually trained nearly 12,000 people as outreach educators, about 800 of whom have become involved in ongoing outreach activities. They included educators recruited from the professional organization of barbers (a group once regarded with suspicion as "spreaders" of HIV), the *devadasis'* economic self-help group, government agencies, a wide variety of youth groups, artistic societies, performance groups and many others.

Other awareness-raising strategies were equally successful. In a rural area with high rates of illiteracy, PLAN/MYRADA decided to take prevention messages directly to the community. Information rallies drew thousands in village squares, as did folk music concerts and major multi-attraction events such



In the traditional art of rangoli, Indian women create intricate patterns with colored powders. PLAN/MYRADA sponsored rangoli competitions on World AIDS Day in order to reach women who might not feel comfortable attending other public events.

Stephen P. Huyler

as those scheduled for World AIDS Day 1995. A bike-a-thon sent ten teams of enthusiastic young people into the countryside to many of the more remote villages to spread the word about HIV/AIDS prevention. Printed educational materials such as brochures and posters were designed with a sensitivity for illiterate or low-literate populations, using design and illustration rather than type alone to deliver prevention messages.

Perhaps the most popular public prevention education events PLAN/MYRADA organized were some 1,900 street theater performances in nearly 500 villages that drew hundreds of thousands of spectators. The plays incorporate HIV prevention messages, condemn the *devadasi* tradition as exploitative of women and encourage the sexes to communicate better with each other about sexual matters.

"There were few educational outreach activities we didn't try," said

Sivaram. "We continually reinforced our messages through various media as well as sheer volume."

### Reaching Women

When women were already organized into self-help groups, labor unions or clubs, PLAN/MYRADA staff found it relatively easy to gain access to meetings and to engage members in educational sessions about HIV and STD prevention. But women in more traditional households seldom participate in such organizations, nor did they feel it appropriate for them to attend some of the public events where discussion of HIV/AIDS took place. Rather than forfeit the opportunity to reach all women with prevention information, PLAN/MYRADA developed a new tactic: organize activities that even women from conservative families would feel comfortable attending.

"Some women are almost never released from duties at home," said Sivaram, "so we learned to take advantage of the narrower range of activities that had long been acceptable for them to be part of."

For example, on World AIDS Day PLAN/MYRADA sponsored competitions in the traditional art of *rangoli*, intricate floral patterns on doorsteps that women create with colored powders. After the winners were announced, staff were able to talk to the participants about reproductive health and HIV and give them brochures about HIV and STD prevention. Similar contests involved other arts and crafts, such as knitting and crocheting—and all presented an opportunity to reach women with prevention messages, sometimes for the first time.

Another traditionally acceptable form of assembly for women is *arshana-kumkum*, the practice of praying in groups for the long lives of their hus-

bands. Through the Family Planning Association of India, PLAN/MYRADA staff received invitations to address these gatherings about AIDS prevention.

Broadening the audience of women the project could reach was only one benefit of using these creative approaches. PLAN/MYRADA staff were especially pleased when women attending such events volunteered to become health educators.

"Their participation helped extend our ability to educate traditional women even further," said Sivaram. "As they became confident about playing a public role in health education, they really made a difference."

### Comprehensive Prevention

All training modules for outreach educators included information on the importance of early treatment for STDs to reduce one's risk of HIV as well as to preserve fertility and health. The message that STDs increase vulnerability to HIV was also incorporated into most of PLAN/MYRADA's materials.

The project sponsored periodic health camps that targeted specific groups more likely to be at risk for STDs, such as truck drivers and sex workers, giving underserved communities access to doctors who could diagnose and prescribe for STDs. In addition to treatment, the camps provided an opportunity for doctors and other staff to counsel patients one-on-one and to offer long-term education and care to organized groups that can be more easily followed and contacted later. More than 250 members of the *devadasi* groups received health cards that enabled them, their partners and their partners' spouses to seek treatment for STDs and other reproductive tract infections.

"Conducting health camps with organizations such as the *devadasis'* self-help groups is probably the most important achievement of the project," said Sivaram. "The success of the partner referral element had the potential to reduce HIV prevalence and perhaps

prevent incident cases of STDs.”

The project also organized workshops to introduce local doctors and clinics to syndromic management of STDs, which bases diagnosis not on test results but on syndromes, which are groups of clinical findings and symptoms. Treatment is then offered for all diseases that could cause that syndrome. The benefits of syndromic management in resource-poor settings such as Belgaum are several: the complex diagnostic process is simplified for health workers without advanced skills, expensive and sometimes unreliable lab tests are no longer needed, and treatment begins immediately.

“We got a mixed reception at first, depending on the kind of medical professional we worked with,” said Sivaram. “Doctors from big teaching hospitals were slightly skeptical, but private practitioners felt this was important information for them.”

Condom education and promotion were also a major programmatic emphasis for PLAN/MYRADA staff. Until the project began, condoms were a less-than-preferred method of family planning, not disease prevention. PLAN/MYRADA incorporated education about condoms and training in their use into all its training and prevention programs and included condom promotion in community events. In partnership with social marketing experts DKT International, PLAN/MYRADA helped create more than 240 community-based sales points for condoms, including convenience stores, roadside betel nut shops, street theater teams and hairdressers. The project has met an important goal: creating enough new outlets so that no one in Belgaum need walk more than ten minutes to buy a condom.

### An Ongoing Commitment

The PLAN/MYRADA project, originally conceived as an intervention targeting the vulnerable *devadasis*, instead succeeded in transforming a large, traditional rural community by improving knowledge and attitudes about HIV and involving community members in their own education and prevention activities. The more inclusive focus on the entire population rather than a marginalized sector ultimately changed the context in which that minority is viewed and treated.

Launching and completing an effort on this scale in such a short time took an enormous amount of hard work. “I think the team effort is responsible for this,” said Sivaram. “But I also credit MYRADA for the years of building such a strong rapport with the community and the government that gave our project such a solid foundation from the start.”

That solid foundation keeps many of the Belgaum prevention activities going strong, even though AIDSCAP funding ended in 1996. The project’s emphasis on widespread regional participation and capacity building of local nongovernmental organizations helped create an ongoing community commitment to maintaining effective prevention efforts until more financial support can be found.

The *devadasi* community also continues to reap the benefits of both the

prevention project and MYRADA’s long-term economic empowerment program. Many have been able to leave sex work for new careers as weavers, basket makers or vegetable vendors. Some have married their former boyfriends, or are limiting their sex work to one or two steady customers.

Back in Soundatti, the annual celebration at the Yellamma temple has also been transformed. What had traditionally been a *devadasi* initiation ceremony has now become its opposite—a “de-initiation” ceremony, where local religious leaders symbolically release the *devadasis* from their vows.

For the day, the square in front of the temple becomes a fairgrounds packed with food vendors and sellers of trinkets and jewelry. Health educators offer information about condoms and HIV, and prevention videos are presented at booths throughout the day. Drama groups perform street plays about the evils of the *devadasi* system and the need to learn about safer sex. The town fills with people arriving from every part of the region and neighboring states.

Later, these same crowds cheer, sing and dance as the priests perform the de-initiation ceremony for a group of *devadasis* seeking a new life. It’s a simple ritual, but one with great psychological power. At its conclusion the women smile and laugh joyfully, their spirits freed of the chains they once feared would imprison them forever. ■

Priests perform holy rites at a “de-initiation” ceremony for almost 1,500 *devadasis*.



PLAN International



# Policy Profile

## Policy Development Initiative Reaps Unexpected Benefits in Central America

*by Bill Rau, Steven Forsythe and Galia Siegel*

Colombia's HIV/AIDS epidemic is far worse than official case reports suggest, and it will have severe economic and social repercussions unless policymakers begin to confront the problem now. That is what the country's leaders are learning from a group of health officials and advocates armed with projections of the socioeconomic impact of HIV/AIDS in Colombia through the year 2000.

These projections were calculated during a policy development workshop funded by the Colombian Ministry of Health and the U.S. Agency for International Development mission in Bogotá. The November 1996 workshop was conducted by the AIDS Control and Prevention (AIDSCAP) Project at the request of Consultores Internacionales

en Seguridad Social y Salud Limitada (CINSSA), a Colombian consulting firm that works with the National AIDS Control Program (NACP).

The invitation to hold such a workshop came during the XIth International Conference on AIDS in July 1996. CINSSA representatives were impressed by what they had heard about a similar workshop organized by AIDSCAP in Central America. They knew that their colleagues from El Salvador, Guatemala and Nicaragua were using socioeconomic impact projections to inform and influence HIV/AIDS policy development, and they wanted to achieve the same kind of results in Colombia.

**Central American Workshop**  
The 15-day training workshop that in-

spired current policy advocacy efforts in Colombia began in February 1996, when interdisciplinary teams from El Salvador, Guatemala and Nicaragua arrived in Guatemala City. Chosen by their ministries of health, the teams included representatives from public health agencies, public sector economic and planning units, nongovernmental organizations (NGOs), academic and research institutions, legislative bodies, the military, social security institutes and international organizations.

The workshop was designed to help technical specialists, policy analysts and policy influencers use the results of socioeconomic impact assessments to inform and guide HIV/AIDS prevention policymaking. Team members agreed to continue working together after the

workshop to develop a gender-balanced, multisectoral response to HIV/AIDS in their respective countries.

During the first two weeks of the workshop, participants learned how to use computer models and costing methodologies to make epidemiologic and economic projections of the impact of HIV/AIDS from 1995 to the year 2000. Each team used data from its own country to assess the potential effects of the epidemic.

During the third week, the country teams developed policy recommendations by analyzing the policy environment in their respective countries and determining how it might be affected by the projected social and economic effects of HIV/AIDS. Then they identified policy areas critical to effective prevention efforts, including integration of HIV/AIDS in school-based family life education, human and civil rights protection, promotion of women's rights and prevention of domestic violence, workplace and immigration HIV/AIDS policies, and public and private sector HIV testing. Policy development and advocacy strategies were created detailing the steps to be taken in support of each recommendation.

The initial action plans for the three countries were similar. Each team intended to create and strengthen support for HIV/AIDS policy initiatives by strategically presenting findings to key audiences, including government ministers, legislators, cabinet members and other national policymakers. Other presentations would be directed toward influential sectors such as the media, the religious community, parastatal institutions, academic and professional associations, NGOs, international donors and the private sector.

Once the teams returned home and began implementing their action plans, the plans were modified considerably. New strategies emerged as the teams encountered different constraints and opportunities. The strategies were adapted to realities of the political environment in each country and reflected the particular composition and coher-

ence of each team, as well as the trends suggested by their socioeconomic projections.

### El Salvador

One strength of the Salvadoran team was the commitment of its members: All but one of the eight Salvadoran workshop participants continued to contribute to the policy development effort after the workshop.

In addition, the team was well-connected with policymakers, including the head of the Salvadoran NACP, the Pan American Health Organization's STD/HIV/AIDS advisor to El Salvador, the Social Security Institute and members of the legislature.

The legislative aides on the team lobbied their committees to increase attention to, and support for, HIV/AIDS prevention activities. Following the workshop, Salvadoran team members had immediate opportunities to present their study findings to members of the National Assembly. These presentations resulted in commitments by Assembly members to support passage of HIV/AIDS legislation, such as a safe blood law, being prepared for consideration in the next legislative cycle.

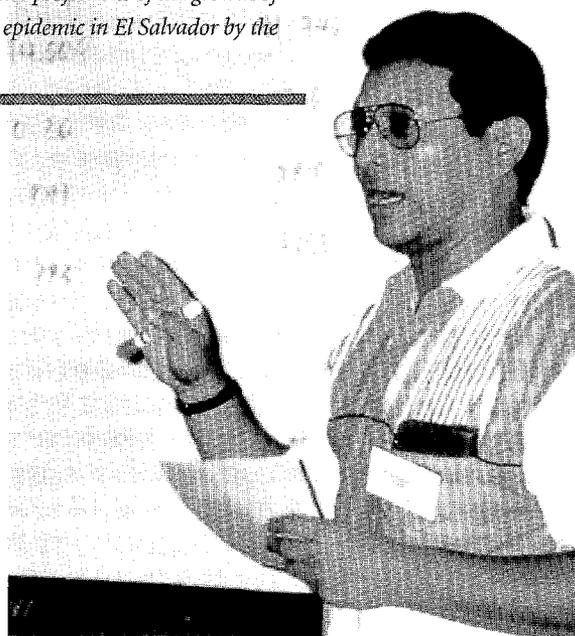
Particularly because El Salvador is emerging from an era of civil war, the potential for HIV/AIDS to disturb the country's fragile economic, political and social stability raised concerns. The team's analysis indicated that up to 23,000 Salvadorans had been infected with HIV by 1995, and that this number could rise to 50,000 by the year 2000. Treatment costs were projected to reach U.S.\$5 million to \$10 million during the same period, with lost income accounting for an additional \$42 million to \$100 million.

The impact assessment used both quantitative and qualitative data to emphasize the potential social and economic costs of the epidemic due to its impact on households and communities, and on the demand on social ser-

vices. This approach—focusing on HIV/AIDS as a development issue—gained the attention of legislators and lobbyists involved in a broad range of issues, including women and families, economic development, human rights, education and environmental health.

The team also presented its projections at Instituto Salvadoreño del Seguro Social (ISSS), a parastatal organ-

*Workshop participant Dr. Ricardo Díaz Fuentes presents his team's projections of the growth of the HIV/AIDS epidemic in El Salvador by the year 2000.*



Steven Forsythe/AIDSCAP

ization that provides health care to private and public sector employees and their families through its own hospitals and health centers. The projected impact on health costs and ISSS operating expenses so concerned the institute's board of directors that it established an HIV/AIDS prevention program for its employees and initiated its own project to strengthen the HIV/AIDS prevention efforts of its private sector clients.

The ISSS board used quantitative and qualitative study data from the AIDSCAP workshop to demonstrate the impact of HIV/AIDS on the workplace as HIV prevalence rises, including potential increases in the employers' required contribution to the social security fund. This effort was launched with presentations to journalists and



*Guatemalan team members discuss computer modeling results on the potential socioeconomic impact of HIV/AIDS in their country.*

business leaders about the socioeconomic impact of HIV/AIDS on Salvadoran businesses and the ISSS. Shrewdly, ISSS board members gave the first presentation to journalists to encourage media coverage of the session with business leaders.

### Guatemala

The Guatemalan team benefited from the participation of the chief of the military health service (Servicio de Sanidad Militar, or SSM), Dr. Cesar A. Rodríguez Duarte. His experience with policy development within the national bureaucracy allowed him to take a lead role in orienting other team members to the Guatemalan policy environment, and his participation in the workshop led him to become an advocate for HIV/AIDS prevention and care within the military.

Dr. Rodríguez also represented the military on a newly formed National HIV/AIDS Coordinating Committee, assuring his continued involvement in dissemination of the study results and in policy development. Since the training, this influential policymaker has

publicly called for a review of policies and practices related to HIV-positive members of the military.

The willingness of the SSM chief to become involved in HIV/AIDS advocacy appeared motivated, in part, by the results of the assessment, which he quoted in several radio and print interviews. The assessment estimated that by the year 2000, 1 of every 100 Guatemalans could be HIV-positive, resulting in 300 AIDS deaths every week. HIV/AIDS treatment costs, estimated at over U.S.\$2,000 per patient, could total \$22 million. As was the case in El Salvador, productivity losses (projected to reach \$140 million to \$220 million by the end of the decade) were expected to be much greater than health care costs.

In addition to Dr. Rodríguez's active involvement in policy advocacy, another unexpected benefit of the AIDSCAP workshop is the improved relationship between the NACP and the Asociación Guatemalteca para la Prevención y Control de SIDA, an HIV/AIDS service and advocacy organization. Despite prior tensions, representatives of the two groups were able to work together on

the socioeconomic impact project. This collaboration bodes well for the efforts of the National HIV/AIDS Coordinating Committee, a multisectoral coalition that brings together diverse, and in some cases historically antagonistic, interests and perspectives to strengthen Guatemala's HIV/AIDS prevention and care programs.

### Nicaragua

The Nicaraguan team benefited from high levels of collaboration among team members. A severe economic downturn, a series of public health crises and an upcoming national election, however, made it difficult for the team to follow through on the activities defined in its action plan.

Fortunately, there were fewer hurdles to policy development in the NGO sector in Nicaragua. Fundación Nimehautzin, a Nicaraguan NGO that was unable to participate in the workshop but was involved in follow-up meetings and strategic planning, was thus able to use the results of the workshop for advocacy purposes and to work with the NACP to pass legislation to protect the human rights of people living with HIV/AIDS. When this legislative effort led to the reconvening of Nicaragua's National AIDS Committee, the assessment team used the opportunity to share their study results with committee members.

The results of the workshop indicated that although the prevalence rate is relatively low in Nicaragua at the moment, HIV/AIDS is expected to be one of the fastest growing epidemics in the country's history. Currently between 2,500 and 8,000 adults have been infected with HIV. By the year 2000 that number may rise as high as 25,000, re-

sulting in more than 70 AIDS deaths a week. Treatment costs could reach more than U.S.\$1 million, and productivity losses could exceed \$50 million.

These socioeconomic impact projections bolstered Fundación Nimehautzin's advocacy efforts, while the NGO provided assistance in the dissemination and policy development efforts of the Nicaraguan team.

### Opportunity and Success

Success in policy development is often incremental and can take unexpected forms, as the experiences of the three Central American teams illustrate. For example, in El Salvador the Social Security Institute's use of socioeconomic impact analysis to sensitize other members of the private sector was not planned. But this form of policy peer education has moved El Salvador into position to engage a critical sector in HIV/AIDS prevention at an early stage of the epidemic. Likewise, the collaboration fostered by the workshop had unanticipated benefits in Guatemala, where it contributed to energizing the National Coordinating Committee—a small but important step in the prevention process in that country. And in Nicaragua, an NGO that was not even involved in the AIDSCAP training linked data generated by the team and advocacy to help steer the country's legislative response to the epidemic.

The experiences of all three country teams reflect a central lesson from AIDSCAP's experience: that policy development success arises from good data, sound analysis, thorough planning and true collaboration. The way that these elements come together depends, in part, on recognition that policy development is a process. Like all good processes, it can be enhanced with strategic planning and the ability to take advantage of unexpected opportunities. ■

---

*Bill Rau is associate director of policy and Steven Forsythe is a health economics officer at AIDSCAP. Galia Siegel was formerly an associate policy officer with the project.*

## In the NEWS *continued from page 2*

joint effort of the AIDS Control and Prevention (AIDSCAP) Project of Family Health International, the François-Xavier Bagnoud Center for Health and Human Rights of the Harvard School of Public Health, and the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Monitoring the AIDS Pandemic (MAP) Network is designed to track the status and trends of the pandemic and share current data with colleagues.

Composed of 80 members from institutions and countries around the world, the MAP Network will collect and analyze information on the status and trends of the global HIV/AIDS pandemic; identify the information needs for improved monitoring and forecasting of the HIV/AIDS pandemic and promote the filling of those needs; and monitor the effects of prevention, care and social interventions on regional epidemics and their impact. The network will disseminate this information through workshops, regional and global consensus reports, and other publications.

An Interim Steering Committee, initially chaired by Dr. Daniel Tarantola of the François-Xavier Bagnoud Center, will direct the MAP Network. The Network's Interim Secretariat will be based at the AIDSCAP Project, which is funded by the U.S. Agency for International Development. For further information, contact: Mary O'Grady, AIDSCAP/Family Health International, 2101 Wilson Boulevard, Arlington, VA 22201, USA; tel: (703) 516-9779, ext. 196; fax: (703) 516-9781; e-mail: mogrady@fhi.org.

---

### TB Treatment Breakthrough

For the first time in decades, the worldwide tuberculosis (TB) epidemic has leveled off, with the number of new cases arrested at about 6 million a year, according to the World Health Organi-

zation (WHO). WHO officials attribute this breakthrough to the use of a new, highly effective treatment strategy.

Computer projections show that widespread use of this strategy, known as "Directly observed treatment short-course" (DOTS), could prevent as many as 10 million deaths during the next ten years.

An estimated 3 million people die from TB every year, making it the leading infectious killer of youth and adults worldwide. TB is also the leading cause of death for people who are HIV-positive.

The resurgence of the disease, which had been on the wane in the industrialized world until the 1980s, is linked by medical experts to the increasing prevalence of HIV infection. HIV-positive people are particularly vulnerable because of their weakened immune systems; worldwide, one-third of those infected with HIV die from TB.

In a recent editorial, Dr. Peter Piot, executive director of the Joint United Nations Programme on HIV/AIDS, called for a dual strategy to beat back the TB/HIV epidemic. "Curbing HIV will help slow the spread of TB," he wrote. "And curing tuberculosis can add years of life to AIDS patients while protecting others from airborne transmission of TB bacilli."

The DOTS strategy that has begun to reverse increases in TB is a multidrug therapy combined with a new health management system involving patient observers who watch patients swallow each dose of medicine. This system is helping TB programs overcome a major obstacle to TB control: patients who take enough medicine to feel better, but stop before they are completely cured and no longer able to infect others. With the introduction of DOTS, TB cure rates have soared. The world's largest DOTS project in China, for example, achieved 94 percent cure rates.

# Resources

---

## **Counseling for HIV/AIDS: A Key to Caring.** World Health Organization.

This book for policymakers, planners and implementers of counseling activities provides guidelines for counseling people affected by HIV/AIDS. It addresses the role of counseling before and after HIV testing, counseling's importance in prevention, and ways in which counseling can empower individuals coping with HIV infection. A number of case studies describe HIV/AIDS counseling experiences. Policymakers and planners can use this HIV/AIDS counseling document as a tool for formulating national policies. For a free copy contact UNAIDS Information Centre, World Health Organization, 20 avenue Appia, Room 72-74, CH-1211 Geneva 27, Switzerland.

---

## **A Transformation Process: Gender Training for Top-Level Management in HIV/AIDS Prevention.** AIDSCAP/Family Health International.

This manual provides guidelines for planning and conducting a gender training activity for senior-level policymakers in HIV/AIDS prevention. It outlines a step-by-step process for mainstreaming gender into HIV/AIDS projects and programs and includes analytical frameworks, four case studies, a bibliography and a gender glossary. Limited copies of the manual and its companion report are available from the AIDSCAP Women's Initiative, AIDSCAP, 2101 Wilson Boulevard, Suite 700, Arlington, VA 22201 USA; fax: (703) 516-9781.

---

## **SEA-AIDS. The South East Asia Inter-Country Team of UNAIDS.**

SEA-AIDS, a new electronic-mail discussion and information service, enables people living or working with HIV/AIDS in the Asia-Pacific region to share experiences, materials and information. It includes an e-mail discussion

group, an electronic archive and a bi-weekly electronic bulletin, SEA-AIDSFlash, about HIV/AIDS in the region. GENDER-AIDS, a sub-network of SEA-AIDS, is devoted to global gender and HIV/AIDS issues.

Other network resources include its *Inventory of HIV/AIDS Resources in the Asia Pacific Region*, a directory of almost 300 resource centers and other HIV/AIDS information sources, and *Get Connected*, a draft paper about the use of electronic networking to strengthen collaboration on HIV/AIDS prevention and care and other development issues.

SEA-AIDS services are provided free of charge to anyone with e-mail facilities. To subscribe, send an e-mail to: sea-aids@lists.inet.co.th. To join the GENDER-AIDS group, send an e-mail to: gender-aids@lists.inet.co.th.

To receive *Get Connected* (55.1Kb, text format) you can 1) send an e-mail to ftpmail@inet.co.th with the following in the message: open get /pub/sea-aids/info/info11.txt or 2) point your WWW browser at ftp://ftp.inet.co.th/pub/sea-aids/info/info11.txt.

To receive a copy of the inventory, contact: The Information Unit, at UNAIDS/APICT, UNESCAP Building, Rajadamnoen Nok Avenue, Bangkok 10200, Thailand; fax: (662) 2881092; e-mail: sea-aids@lists.inet.co.th. Include name, address and affiliation.

---

## **AIDS Educational Game. Teaching-Aids at Low Cost (TALC).**

This game is a sexual health teaching tool for children, youth and adults. Players move around the board, which is designed to resemble "Snakes and Ladders," after correctly answering questions about HIV/AIDS. The game contains two sets of questions—one for children of upper-level primary school age, the other for adolescents and adults. The cost is £5.25 (including surface postage). Contact TALC at P.O. Box 49, St. Albans, Herts AL1 5TX, United Kingdom; fax: 44 172 784 6852.

---

## **Private Sector AIDS Policy.** AIDSCAP/Family Health International.

The Private Sector AIDS Policy (PSAP) materials are a combination of "how-to" manuals that provide a step-by-step approach to planning and implementing HIV/AIDS prevention programs and policies for businesses. While these materials are specifically designed for the African private sector, they can be applied to businesses around the world. The PSAP materials consist of six modules that enable business managers and workers to estimate potential costs of HIV/AIDS to businesses; to develop a team management approach to HIV/AIDS programs; and to design or expand workplace prevention policies and programs. Also included is a compilation of African workplace case studies, as well as a guide for conducting a workplace policy needs assessment. A limited number of copies are available. Contact Bill Rau at AIDSCAP, 2101 Wilson Boulevard, Suite 700, Arlington, VA 22201, USA, or by e-mail at brau@fhi.org.

---

## **Working with Young People on Sexual Health and HIV/AIDS.** AHRTAG & Hand-in-Hand Network.

This 64-page illustrated resource pack is designed to help health workers, community educators and teachers address sexual health and HIV/AIDS issues with youth. It includes a list of more than 80 key resources, which range from training manuals and teaching tools to games and comics. All are adaptable for use in developing countries and are available at low cost or for free. This resource pack is free to people in developing countries and £5/US \$10 for readers elsewhere. Contact the Hand-in-Hand Network, c/o AHRTAG, Farringdon Point, 29-35 Farringdon Road, London EC1M 3JB, United Kingdom; fax: 44 171 242 0041; or e-mail ahrtag@gn.apc.org.