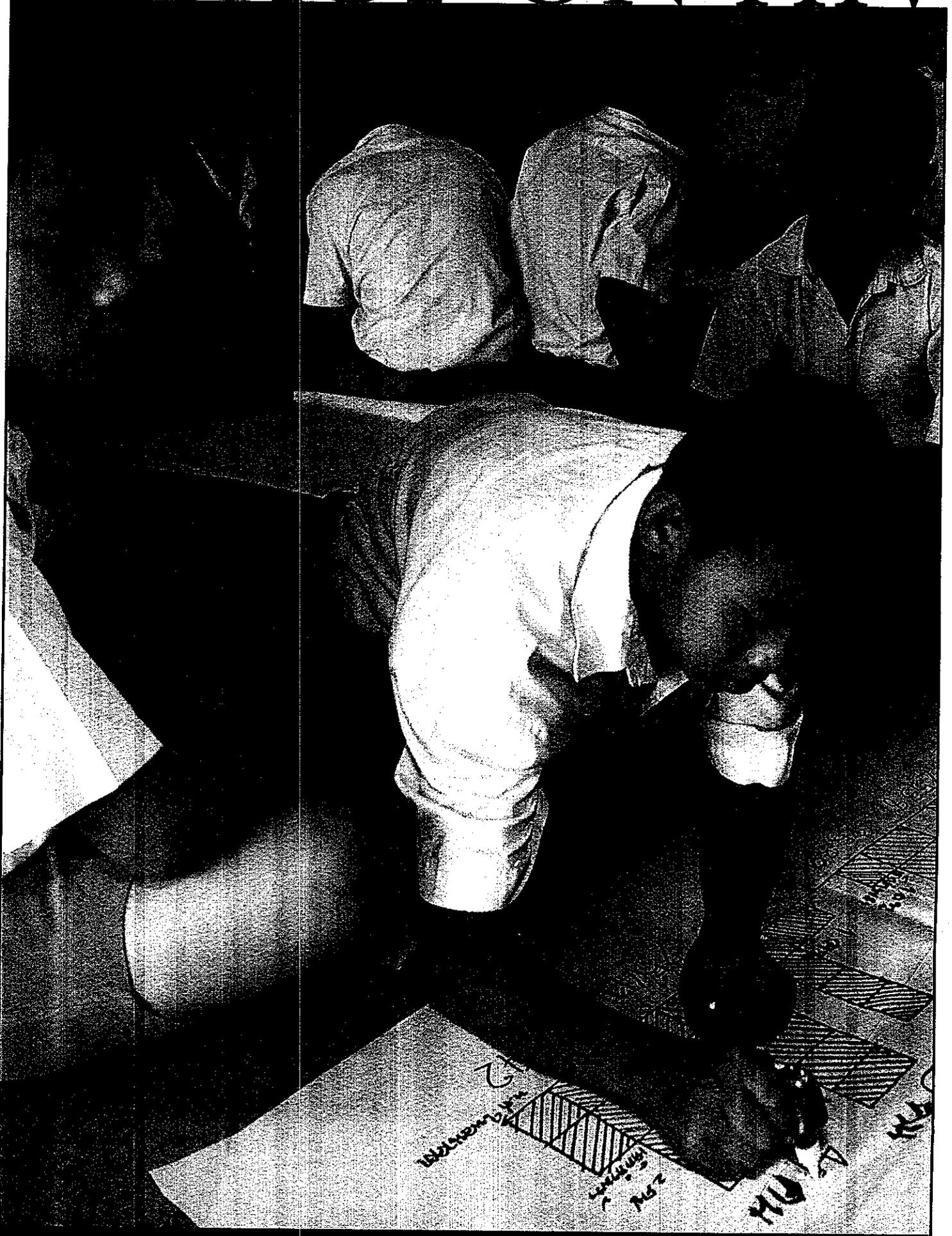


IMPACT ON HIV



IN THE NEWS

Mother-to-Child Transmission Recommendations

Experts have advised the World Health Organization (WHO) that the safety and effectiveness of antiretroviral (ARV) regimens that prevent transmission of HIV from mother to child warrant their use beyond pilot projects and research settings.

This was the conclusion of a WHO technical consultation, held in Geneva Oct 11-13, 2000, on behalf of a United Nations interagency task force on the prevention of mother-to-child transmission of HIV. The meeting brought together scientists, managers of national HIV/AIDS programs, HIV-positive mothers, and representatives of UN agencies and nongovernmental organizations from Africa, Asia, Europe, the Caribbean and the Americas.

Meeting participants also recommended that prevention of mother-to-child transmission of HIV be considered part of the minimum standard of care for HIV-positive women and their children.

The safety of preventive treatments, including zidovudine (AZT) alone, zidovudine and amivudine, and nevirapine, has been studied in both breastfeeding and non-breastfeeding populations worldwide. Information currently available does not suggest any adverse effects on the health of mothers, the growth and development of infants, or the health and mortality of infants who become infected despite preventive therapy.

The most complex regimen includes zidovudine for the mother during pregnancy,

labor and delivery and postnatal doses for the infant. The simplest regimen requires a single dose of nevirapine at the onset of labor and a single dose for the newborn.

Recommendations from March 2000 had stated that because of possible concerns about the rapid development of nevirapine-resistant virus in women using this intervention, nevirapine should be used only within the context of pilot and research projects.

Resistant virus may develop quickly to ARV drug regimens that do not fully suppress viral replication, such as those including lamivudine and nevirapine, but evidence indicates that virus containing drug-resistant mutations decreases once the antiretroviral drugs are discontinued.

Mutant virus might remain present in an individual at very low levels, and this could reduce the effectiveness of future ARV treatments for the mother. However, the meeting concluded that the benefit of decreasing mother-to-child HIV transmission with these ARV drug regimens greatly outweighs any theoretical concerns.

Preventing mother-to-child transmission, however, involves more than simple provision of antiretroviral drugs. It also requires appropriate voluntary HIV counseling and testing services, as well as support for mothers and infants, including counseling on infant feeding options.

HIV Prevention Trials Network

The U.S. National Institutes of Health (NIH) has selected 25 research institutions in 13 countries to join the cooperative HIV Prevention Trials Network (HPTN), a five-year global effort to evaluate promising interventions to prevent the spread of HIV.

Funded by several institutes within NIH, HPTN will conduct research on means of reducing HIV transmission. This research will focus on six areas: preventing mother-to-child transmission of HIV; microbicides; controlling other sexually transmitted infections; changing behaviors that expose people to HIV; reducing substance abuse; and using antiretroviral drugs to prevent transmission of HIV.

In 1999, NIH chose Family Health International to lead and manage the HPTN. FHI

is joined by Johns Hopkins University, which provides the central reference laboratory for the network, and the Fred Hutchinson Cancer Research Center, which serves as the network's statistical and data coordinating center.

The HPTN continues work begun in 1993 through the HIV Network for Prevention Trials (HIVNET) sponsored by the National Institute for Allergy and Infectious Diseases (NIAID). Under this earlier effort, FHI oversaw vaccine and non-vaccine HIV prevention studies in 11 non-industrialized countries.

NIAID is HPTN's lead sponsor. Other NIH cosponsors of the network include the National Institute of Child Health and Human Development, the National Institute of Mental Health and the National Institute on Drug

Abuse. Funding for the first year of the project totals slightly over \$US 30 million.

Scientists worldwide competed for inclusion in the HPTN through a peer-reviewed evaluation process. Seventeen investigators have been chosen to lead the research at nine sites in the United States and 16 sites in non-industrialized countries.

The research sites outside the United States are in the following countries: Malawi, South Africa, Tanzania, Uganda, Zambia and Zimbabwe in Africa; China, India and Thailand in Asia; the Russian Federation in Eastern Europe; and Brazil and Peru in Latin America.

NIH will also sponsor clinical trials of HIV vaccines through a similar cooperative effort known as the HIV Vaccine Trials Network.

CORRECTION

Due to editorial error, the people pictured on pages 10, 15 and 17 were misidentified in the captions for the article entitled "INP+: India's HIV-Positive People Unite Against Discrimination and Repression" in some issues of the June 2000 IMPACT on HIV before the errors were discovered. IMPACT on HIV regrets these misidentifications and apologizes for any inconvenience they may have caused the individuals concerned.

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IMPACT ON HIV

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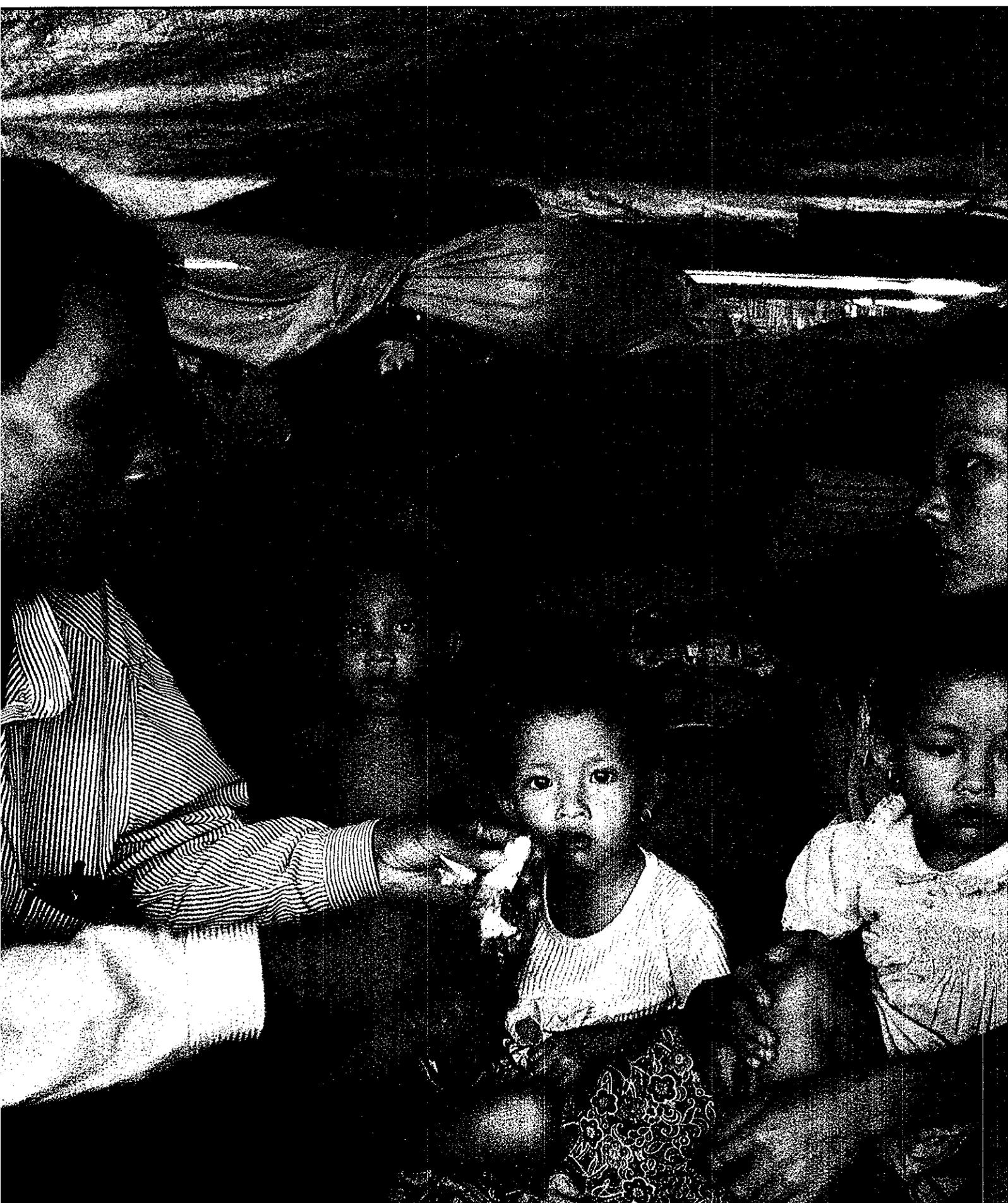


Cover photo: Thai schoolboys plot projections of growth in HIV/AIDS cases.

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A social worker visits a family affected by HIV/AIDS. HIV-positive women may be excluded from their communities because of their serostatus.

Making an Impact on HIV/AIDS in Cambodia

BY GILL FLETCHER

In Cambodia, where desperate poverty drives Asia's worst HIV/AIDS epidemic, comprehensive prevention programs are beginning to have an impact on the spread of the virus.

Now at peace after a recent history of genocide and 20 years of civil war, Cambodia faces another deadly threat. Nearly 8,000 people in the country are expected to die of AIDS in 2000—an average of 20 people a day.

Cambodia has the most severe HIV/AIDS epidemic in Asia, with an estimated 170,000 adults living with HIV/AIDS in 1999. That's out of a population of around 11.5 million people, more than 42 percent of whom are younger than 15 due to high birth rates, gradually improving health and, in some part, to lives lost during the years of conflict.

This epidemic is one of many challenges facing a country where Khmer Rouge genocide, famine and civil war killed at least 1.7 million people and destroyed whole infrastructures in education, health and transport. Today

Cambodians work to rebuild their country amid enormous social inequalities, low levels of food production, and high levels of homelessness and poverty. But despite this daunting post-war legacy, the country's leaders are working with local and international nongovernmental organizations (NGOs) to mount an impressive multisectoral response to HIV/AIDS.

"Luckily for Cambodia, its government recognized the scale of the country's HIV/AIDS problem early on and took measures to respond," said Francesca Stuer, country director of Family Health International's programs in Cambodia.

Cambodia's National AIDS Program, established in 1991, has developed into the National Center for HIV/AIDS, Dermatology and Sexually Transmitted Diseases (NCHADS), which manages HIV/AIDS prevention and care efforts nationwide. The National AIDS Authority (NAA), chaired by the Minister of Health with

the Prime Minister as honorary chairperson, is responsible for coordinating the Cambodian government's response to the epidemic by working to ensure that all Cambodian ministries and provinces integrate HIV/AIDS initiatives into their policies.

But NCHADS and the NAA know they cannot succeed alone. Their resources are limited, and the problem is great. Hence, there is national acknowledgment of the need for partnerships between the public, social, NGO and business sectors. Prime Minister Hun Sen emphasized this point in his closing address at Cambodia's first

international conference on AIDS in March 1999. "This is not just an issue for the government," he said. "Everybody should be involved."

Encouraging Trends FHI established the Implementing AIDS Prevention and Care (IMPACT) program in Cambodia, which is funded

by the United States Agency for International Development (USAID), in 1998. Through IMPACT and other projects, FHI works with the government at the national level to conduct studies and inform policy development and with NGOs at the community level to support and strengthen HIV/AIDS prevention and care.

An important collaboration between FHI/Cambodia and the NCHADS is the technical assistance FHI provides on the national surveillance system. Based on the principles of "second-generation surveillance" outlined by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO), this system uses several different sources of data to decipher trends in the prevalence of HIV and other sexually transmitted infections (STIs) and in the behaviors that put people at risk of infection.

"Luckily for Cambodia, its government recognized the scale of the country's HIV/AIDS problem early on and took measures to respond."

Every year, the NCHADS staff conducts a national HIV Surveillance Survey (HSS) in which people in selected groups are tested anonymously for HIV. Levels of risk behaviors for many of the same groups are assessed by analyzing interview data from annual behavioral surveillance surveys.

The groups included in the surveys are chosen according to the current stage of the epidemic in Cambodia. As a result, Cambodia's surveillance system monitors HIV, STIs and HIV risk behavior in those at highest risk of infection—primarily female sex workers and their partners, as well as those who might provide a “bridge” for HIV from these sexual networks to the rest of the population. It also includes pregnant women attending antenatal clinics, who are considered a reasonable proxy for the general population.

Though the surveys have found high levels of HIV infection and HIV risk behavior in Cambodia, there is some good news. Results from the 1999 HSS show that the epidemic might be declining among several groups at high risk of HIV infection. There is also no evidence of rapid increase in the national prevalence of HIV among women visiting antenatal clinics during the past few years, indicating that rates of transmission in the general population are fairly stable.

Data from three rounds of BSS suggest that these trends may result from behavior change. For example, the percentage of sex workers who work in brothels reporting that they always use condoms with their clients has risen steadily, increasing from 42 percent in 1997 to 78 percent in 1999.

These are encouraging signs, but they must be interpreted cautiously. “Improvements in the quality of data available each year may mean that previous estimates were too high, rather than indicating a true drop in prevalence,” said Dr. Hor Bun Leng, deputy director of the NCHADS. “It is too early to conclude that Cambodia is an HIV prevention ‘success story.’”

Data for Decision Making Dr. Tobi Saidel of FHI's Asia Regional Office in Bangkok, Thailand, is a member of the team of consultants who provide technical support in data management and analysis for the HSS. She notes that the 1999 surveillance data offer hope and a warning at the same time.

“Prior to 1996, it was more difficult to predict which way the trends would go,” she said. “The figures in the last few years are more comforting, since we now see indications of a leveling off of trends among high-risk groups and the general population.”

However, Dr. Saidel points to other worrisome trends, including evidence of an expansion of HIV transmission dynamics beyond sex workers and their clients. “The gap between the per-

centages of infected males and females is closing, indicating that transmission is increasingly occurring between men and their regular sexual partners,” she explained. “In addition, there are rising concerns about shifts from brothel-based commercial sex to more indirect venues, such as bars, karaoke lounges and massage houses, which could make conditions right for a new wave of infections.”

Given these trends, Dr. Saidel concludes, “Cambodian officials are wise to retain a highly vigilant stance with regard to the epidemic.”

Like current HIV prevention efforts, the response to these new trends in the epidemic will be driven by data. The talented and dedicated staff of NCHADS and the support they receive from donors such as USAID, the French Cooperation for Development, UNAIDS, WHO, the United Nations Children's Fund (UNICEF) and the Cambodian World Bank project have enabled Cambodia to maintain a continually improving surveillance system that provides data to inform program implementation.

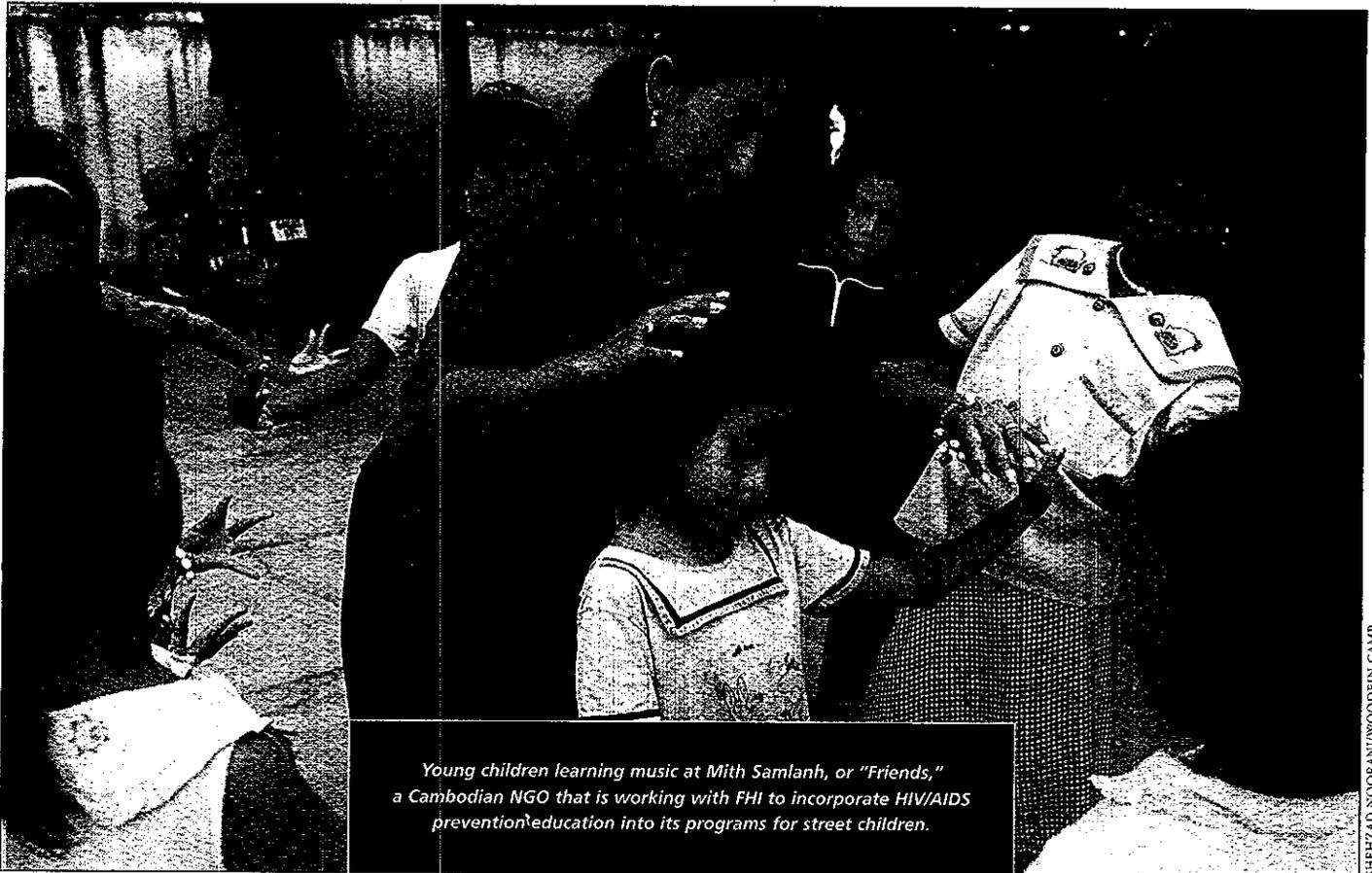
FHI/Cambodia uses HSS and BSS results, along with STI prevalence data, to identify the groups most at risk of HIV infection and the behaviors that put them at risk. More in-depth behavioral studies reveal constraints to individual behavior change and opportunities to support such change, and this informa-

tion is used to guide program design. With this information, the project—working through an HIV/AIDS prevention and care network of local NGOs and government agencies—has been able to reach out to members of the uniformed services, sex workers and their clients, street children, and mothers and children affected by AIDS.

Findings on the expansion of the HIV epidemic beyond high-risk sexual networks have prompted responses from FHI/Cambodia. For example, FHI is supporting the Nyemo Counseling Center for Women and Children Living with HIV/AIDS, which provides a safety net for families headed by women who are infected with HIV in Phnom Penh. Often separated from their extended families, these women either have been, or are at risk of being, excluded from the communities in which they live because of their HIV status.

The Nyemo Center will strengthen and expand the existing woman-to-woman support networks in Cambodian society, which already sees women taking responsibility for and caring for children from both within the extended family and from outside. Birth families often hand over their children if they feel that another family could look after them better. This practice seems to be based in an existing sense of communal responsibility for chil-

Though the surveys have found high levels of HIV infection and HIV risk behavior in Cambodia, there is some good news.



Young children learning music at Mith Samlanh, or "Friends," a Cambodian NGO that is working with FHI to incorporate HIV/AIDS prevention education into its programs for street children.

SHEHZAD NOORANI/WOODFIN CAMP

dren's well-being; however, the ties are loosened when women are physically or emotionally distanced from their extended families.

There is also a danger that, because of the possible stigma around HIV/AIDS and the increasing numbers of children being orphaned by AIDS, this natural coping mechanism may break down. Thus, the Nyemo Counseling Center will support communities and individuals in strengthening existing coping mechanisms and encouraging a sense of communal responsibility for the welfare of HIV-positive women and their children.

"Broken Women" Phan Vuthy, research team leader with Action, the NGO that develops information, education and communication materials for the IMPACT/Cambodia program, is not surprised by the finding that HIV seems to be moving into the general population.

"Every week one, two or three people living near to my mother's village die from AIDS," he said. "Every week. We all know about it."

Most of those who die, Phan Vuthy reports, are men with families — "moto taxi drivers, farmers, ordinary men." He adds that these men probably "went to play" with sex workers.

As a rule, in Cambodian society sex within marriage is for procreation, while sex with sex workers is for recreation. Men of all levels of education and social status make use of the brothels, bars and other sex work sites that can be found in larger villages and towns across Cambodia. It is particularly common for unmarried men in their late teens and early twenties to patronize sex workers: an active libido is considered a sign of strength, and most

young men have no alternative to commercial sex but abstinence. A Cambodian marriage is permitted only if the man can prove he can support a family, and many men must save for years before they can marry and have access to sex within marriage.

In Cambodia, as in many cultures around the world, sex workers are treated more judgmentally than those who use their services. In Khmer, the common phrase for sex worker is *srey khoch*, or "broken woman." All it takes for a woman to be "broken" is for her to lose her virginity outside of marriage—even if she loses her virginity through rape. Once broken, goes the Cambodian belief, she can never be repaired. The loss of virginity outside of marriage is a non-negotiable loss of "acceptability."

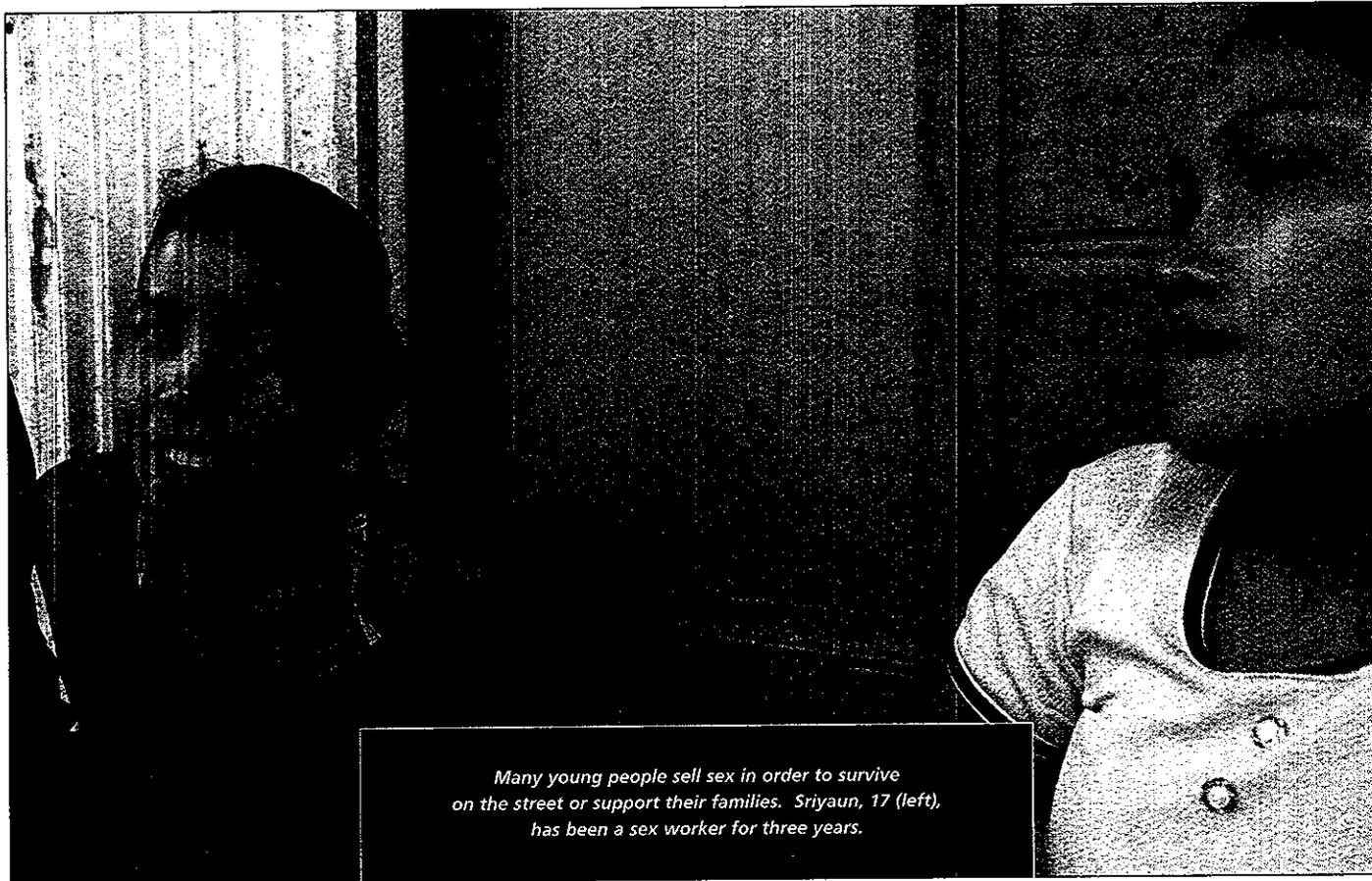
The stories of four young women who work in a well-known Phnom Penh site for commercial sex are illustrative of the difficulties many women face in Cambodia. Each has a mother or father and siblings who depend on her meager earnings, yet not one of the women would tell her family

what she did. They all pretended to do other work. "If my mother or father knew what I do, they would not accept the money," said Sophal, 20. "They would be angry."

"I feel difficult in myself, doing this," added Sophy, 31. "Each time I earn 20,000 riel [about \$US 5—the amount Sophy hopes to earn for one sex act], I feel like crying. It is bad work. But I feel forced to do it because I have no money."

The women provide emotional and practical support to each other and use condoms when they can, but it's not easy. Srey—who is 31 years old but tells prospective clients she is 26 so they

"Every week one, two or three people living near to my mother's village die from AIDS."



Many young people sell sex in order to survive on the street or support their families. Sriyaun, 17 (left), has been a sex worker for three years.

SHEHZAD NOORANI/WOODFIN CAMP

won't think she is too old for them—explains that sometimes men want only “the very pretty girls.”

“Sometimes I have met three, four, five men, and they haven't wanted me,” she said. “I have no choice. If I don't have any money, then I will accept someone who only wants to pay 5,000 riel or 10,000 riel [just over one U.S. dollar or \$2.50]. And sometimes it is very difficult to say they must use a condom. By that time, there are just the two of us in the room, and I have to do what the man wants. I cannot force him to do anything.”

Empowering Women Srey, Sophy and other Cambodian sex workers are slowly finding strength from each other and from a number of local organizations. Staff members from one of FHI/Cambodia's partners in the IMPACT program, Cambodian Women for Peace and Development (CWPD), have spent months gradually building relationships with women working in brothels and in shared, rented spaces, winning a little of the trust the women understandably find so hard to give. Now “team leaders” have been elected from among the sex workers, and CWPD is working with the women to develop skills for negotiating safer sex and to build their sense of self-worth. It's hard for the women to value their health if they are constantly told that their only worth is to service men's desires.

The women are encouraged to try to save money. Refusing sex without a condom becomes a lot more difficult if you are desperate and have no money at all. CWPD also lobbies on

behalf of the women and helps them get regular STI and general health checkups.

Phnom Srey Association for Development (PSAD) works in a similar way with different groups of women. The association is supported by FHI/Cambodia's IMPACT program to reach out to more than 200 young women who work in karaoke bars and brothels in Kompong Cham, the most heavily populated province in the country.

Large numbers of soldiers regularly pass through the town of Kompong Cham, which is the headquarters for Military Region 2. It also has a major port and houses the largest market in the region, which draw many more men in and out of the town,

making it a prime site for commercial sex. Scores of karaoke bars are home to hundreds of women who work in the bars but are often asked for sex by clients. Some are threatened with the loss of a job and home if they refuse a man. Sex is sold either in karaoke bar back rooms or in nearby guesthouses. There are

some brothels, but the police regularly crack down on them, taking money from sex workers and brothel owners alike or simply closing businesses down.

Back in Phnom Penh, the Urban Sector Group (USG) also emphasizes empowerment in its work with another group of women involved in commercial sex. Known colloquially as “orange sellers,” these women charge just 5,000 riel (under \$1.50) for sex. Their unusual name comes from times past when single women in the parks did indeed sell only oranges.

“Sometimes it is very difficult to say they must use a condom. By that time, there are just the two of us in the room, and I have to do what the man wants.”

Peer Educators Arm Military, Police Against HIV

Yim Akhara is chief of the Health Office for the Cambodian Navy. It's an important job, yet he unhesitatingly finds time to take on an extra workload, supporting an innovative HIV/AIDS project for members of Cambodia's uniformed services.

Why? "In my unit in 1994, we had to do some medical screening for staff who were going abroad," he explained. "We found that five men out of 75 were HIV-positive. They are all now dead. They all had families.

"It was very difficult because we didn't know how to help those men," he added. "That was before we began to work with FHI. Now I hope that I can help my colleagues to protect themselves from HIV."

The latest statistics show that his colleagues in the military, police force and the Cambodian Mine Action Center are in need of protection from infection. Seven out of every 100 men in these services are infected with HIV. That's second only to HIV rates among sex workers.

To reduce HIV among this group at high risk of infection, FHI/Cambodia's IMPACT program is assisting the Ministry of National Defense and the Ministry of the Interior in establishing and running peer education programs for the uniformed services. Currently operating in Kandal Province, Phnom Penh and

Kampong Cham, the project is the largest single HIV/AIDS intervention with Cambodia's police, members of the military and the "deminers" who find and disarm the many explosive mines and unexploded bombs left scattered about the country after years of conflict.

Dr. Akhara is one of a team of "core trainers" at the top of a training pyramid designed to ensure that every unit involved in the program will have its own peer educators. The huge numbers involved make it impossible for FHI/Cambodia to train all the peer educators needed, so FHI trains core trainers, who then train peer educator

trainers, who in turn train peer educators. Each stage also has "quality control" built in, to ensure that the training meets the standards set for the initial work with the core trainers.

Colleagues can easily identify the peer educators within their units by the T-shirts and baseball caps they wear, which proclaim in Khmer: "AIDS. Come and talk to me." And, gradually, more

and more members of the military are going to the peer educators for information and advice on protecting themselves and their loved ones.

These men are the public face of a program that, although currently implemented only in a small part of Cambodia, already reaches out to 30,000 members of the

uniformed services. The peer education program thus seeks to benefit Cambodian society as well by helping the men protect their wives, unborn children and other sex partners, including sex workers.

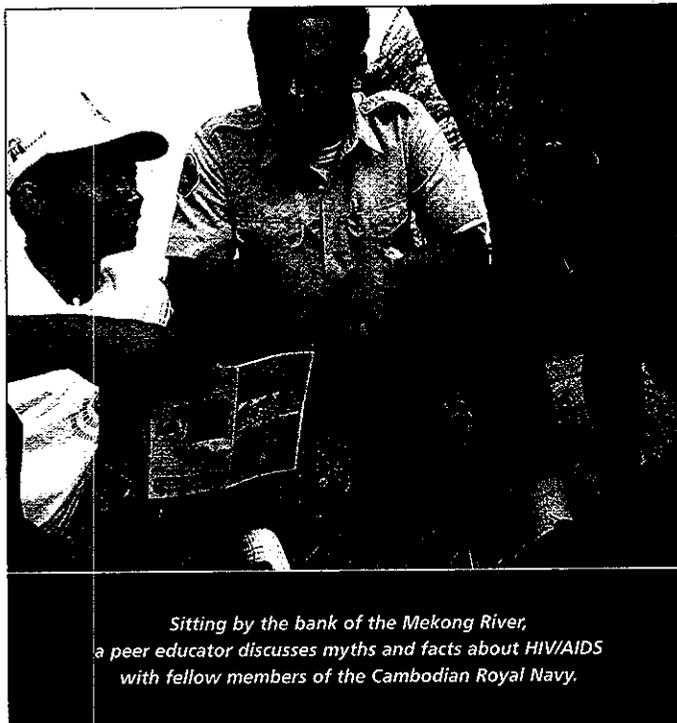
The most recent round of behavioral surveillance surveys in Cambodia revealed that slightly more than 55 percent of men in the military had visited a sex worker within a month of being interviewed. Unsafe sexual behavior is often influenced by peer pressure; alcohol, lust and condom use can be uneasy bedfel-

lows. Peer education helps the members of the uniformed forces to reconcile such conflicts—and to think about their own responsibilities when it comes to HIV prevention.

Recent data suggest that HIV prevalence may be stabilizing among police, an encouraging sign that prevention efforts are beginning to have an impact.

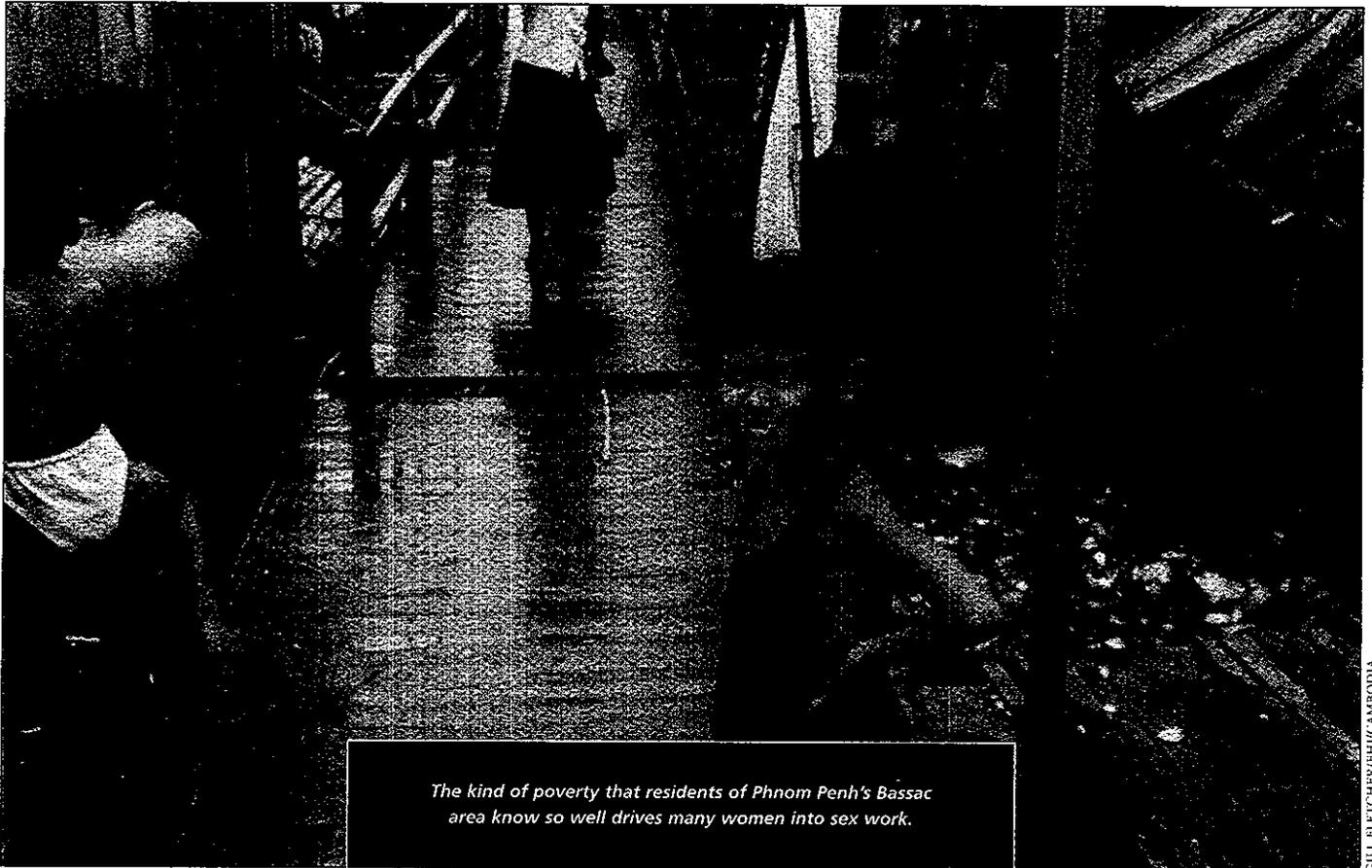
"If there was no peer education program, then the HIV epidemic would spread very fast among the military," said Dr. Akhara. "I am glad to be a core trainer. I think about my friends, about the people I work with, and about their families."

More and more members of the military are going to the peer educators for information and advice on protecting themselves and their loved ones.



Sitting by the bank of the Mekong River, a peer educator discusses myths and facts about HIV/AIDS with fellow members of the Cambodian Royal Navy.

SHEHZAD NOORANI/WOODFIN CAMP



The kind of poverty that residents of Phnom Penh's Bassac area know so well drives many women into sex work.

GILL FLETCHER/FHI/CAMBODIA

Then they began to sell “squeezed oranges,” or breast fondles, and now they usually sell oranges and commercial sex. Many of Phnom Penh’s orange sellers live in Bassac, one of the city’s most impoverished areas, where ramshackle shacks made out of banana leaves perch precariously on stilts over the mudflats of the river, Tonle Bassac.

With one-third of the country’s female sex workers infected with HIV and an epidemic believed to be fueled by male-female sex, the NCHADS has paid much attention to the need for condom use in sex work. Sex workers are encouraged to have regular tests for STIs and HIV, condoms are made easily available through social marketing schemes, and a 100 percent condom use policy is being implemented with support from a range of organizations, including FHI. The policy aims to ensure that condoms are used in every sexual transaction in every brothel in selected communities. This “blanket” use of condoms in very high-risk-transmission situations has been shown, from the experience in Thailand where the first such policy was developed, to play a significant role in reducing the incidence of STIs and HIV.

In Cambodia, if a client refuses to use a condom, sex workers are urged to withhold services and refund the client’s money. All sex establishments are required to be involved in the project to limit clients’ ability to purchase sex in other places without using condoms.

Common Threads It’s no coincidence that sex work and poverty go hand in hand in Cambodia. In a society that puts such a high premium on virginity and faithfulness to a husband, sex work is the refuge of desperate women: women with little or no education and often with a cultural imperative to help support their families.

“Poverty affects nearly all of the groups with which we work,” said FHI/Cambodia Country Director Stuer. “People who don’t know where the next meal is coming from are far more likely to display high-risk behavior, to have little or no concept of the need to plan or protect themselves for the future, and to have little or no power when

it comes to negotiating safer sex because of their often overwhelming financial needs.”

It should come as no surprise, therefore, that many street children sell sex. Both boys and girls know that if they sell themselves, they can earn money to eat. Often they go to the streets because their families are too poor to support them.

In fact, many young boys and girls work to support their families.

Mith-Samlanh, or “Friends,” works to educate and support Phnom Penh’s street children. Among its many activities, Friends provides HIV/AIDS interventions with technical and financial support from FHI/Cambodia. The aim is to equip the street children with the tools they need to help protect themselves from risk and to work with them on the much more nebulous areas of self-esteem and a sense of the future.

In a society that puts such a high premium on virginity and faithfulness to a husband, sex work is the refuge of desperate women.

Street children usually report having higher numbers of sex partners than other young people their age, sniffing glue and generally taking greater risks with their health. They live from day to day, and find money where they can.

Such survival is, in itself, testimony to the strength of the children, and Friends works hard to build up the children's faith in their own capacities and in the possibility of a better future. It does so by offering education, health care, and emotional and practical support and through projects that aim to raise the children's self-esteem by giving them responsibility, the power to make decisions, and the assurance that their views are valued. One way Friends does this is by involving street children in its decision making and project planning.

Such a holistic approach is one of the common threads that bind the FHI/Cambodia program together. Partners in the program's HIV/AIDS prevention and care network share similar goals, approaches and challenges.

To strengthen the linkages among these partner organizations, FHI holds regular meetings and training workshops and, where possible, provides opportunities for partners to work together on intervention projects.

"The different agencies working in HIV/AIDS in Cambodia are all keen to support and learn from each other," said Stuer. "And we are all working to build greater links between Cambodian mainstream society and members of the high-risk groups, who are often seen as being outside of society."

Ultimately, all FHI projects and activities are designed to build the country's own capacity to deal with the HIV/AIDS epidemic. "Any interventions carried out by FHI/Cambodia's partner agencies are based within the communities which they serve," Stuer said, "and both successes and issues encountered along the way are fed into the development of national strategies."

GILL FLETCHER IS A VOLUNTARY SERVICES OVERSEAS (VSO) VOLUNTEER WORKING AS EDITOR/DESKTOP PUBLISHER WITH FHI/CAMBODIA. SHE HAS SERVED AS A JOURNALIST, COPYWRITER AND COMMUNICATIONS PROJECT MANAGER FOR A WIDE RANGE OF BRITISH NGOS AND IS ALSO A PHOTOGRAPHER.

THE NAMES OF ALL THE SEX WORKERS QUOTED IN THIS ARTICLE HAVE BEEN CHANGED AT THEIR REQUEST.

Sopeap's Story

Sopeap, 16, is the eldest of six sisters. Their father—who was violent toward their mother—earned money riding a cyclo (similar to a rickshaw), and the family struggled to earn enough to eat. So after just three years of school, Sopeap was sent to help her mother sell vegetables at the market. At age 13, she was kidnapped and sold to a brothel miles away from her family.

The resultant rape changed what Sopeap now accepts as her position in life. "When a girl is not a virgin anymore, everybody can see it," she said.

Having lost her "honor," Sopeap spent six months in the brothel. Then she managed to steal some money from a client, took a taxi back to Phnom Penh, borrowed clothes from girls she met, and "began to work and sell sex myself."

Sopeap has renewed contact with her mother, who is sick and can no longer work. She gives her mother money when she can and worries about what will happen to her young sisters, who must work instead of going to school. They beg, sell small snacks on the street and collect waste, which they sell to adults who in turn sell it to recycling organizations. Once her sisters pass

puberty, sex work will be another, slightly more economically viable, option—albeit an extremely limited one.

The sale of virginity brings with it a relatively high price (perhaps as much as \$US 400, split between the family and the brothel or go-between to the sale). But the income from sex work goes downhill from then on, in stark contrast to the social, personal and health costs of sex work.

Sopeap says she does not earn much. "When I cannot find a customer, I just don't have anything to eat," she added. Such desperation means Sopeap will always accept a customer—whether or not the customer wants to use a condom.

An HIV/AIDS program can't give Sopeap the money she needs to live. It can't restore her "honor." But such programs can offer more than just information about preventing HIV and other sexually transmitted infections. They can give Sopeap and others like her education and training to help them find more lucrative work and help them save the little money they have. Perhaps most important, they can help these young women develop self-esteem and negotiating skills so that they can protect their health.

*"When a girl is not a virgin anymore,
everybody can see it."*



*IMPACT helps families discuss
HIV prevention and cope
with the effects of HIV/AIDS.*

Realizing the HIV Prevention-to-Care Continuum in Kenya

BY GEORGE OBANYI AND LEE PYNE-MERCIER

A program that combines intensive behavior change interventions with community-based care and support for individuals and families affected by HIV/AIDS aims to make the prevention-to-care continuum a reality in Kenyan communities.

When Mary tested HIV-positive at the hospital where she had sought care for frequent illnesses during her pregnancy, she was sure there had been a mistake. A second test confirmed the result. "It was difficult to absorb the shock," she said. "I was worried about my baby."

Local health workers could not provide much assistance. They referred the 27-year-old expectant mother to Kenyatta National Hospital in Nairobi, almost 400 kilometers from her home in Kenya's Western Province.

What followed was intensive counseling on positive living with HIV. The information and encouragement she received from counselors at Kenyatta helped Mary accept her HIV status and face the challenges ahead, including the death of her husband a few months later and raising her children alone.

This kind of support will soon be available closer to home at a new HIV voluntary counseling and testing center at St. Mary's Hospital in the Western Province town of Mumias. Family Health International's Implementing AIDS Prevention and Care (IMPACT) program in Kenya is providing technical assistance to establish this center, with funding from the United States Agency for International Development (USAID).

Through the Mumias center and 11 other voluntary HIV counseling and testing centers, FHI/IMPACT will link interventions to reduce the risk of HIV/AIDS among vulnerable populations with community-based care and support for those already infected or affected by the virus. Outreach workers and volunteer peer educators will refer people to the centers and help them change the behaviors that put them at risk of infection. Those who test positive for HIV and their families will be referred to community-based teams of caregivers and other nearby sources of support.

Such linkages are one of the hallmarks of a new generation of programs responding to the challenges of HIV/AIDS prevention

and care in areas with high HIV prevalence, according to John McWilliam, the FHI country director in Kenya.

"Many programs are working on prevention in one part of the country and care and support in another part of the country—hence the target community does not see the connection," McWilliam said. "IMPACT is addressing the needs of the uninfected through prevention and clinical service interventions, the infected through care and palliation, and the affected through psychosocial support interventions in a given target community."

Priority Communities Almost everyone in Kenya knows about AIDS and how deadly it is. A recent IMPACT study carried out by the Program for Appropriate Technology in Health (PATH), however, found that there is widespread misunderstanding of the relationship between HIV and AIDS. The National AIDS and Sexually Transmitted Disease Control Programme (NASCO) estimates that 2.2 million Kenyans will be living with HIV by the end of the year 2000 and 3 million, or 15 percent of the total population, will be infected by 2005.

Reversing this trend calls for strategies that incorporate lessons from past interventions and intensify proven approaches. FHI's experience with its USAID-funded AIDS Control and Prevention (AIDSCAP) program in Kenya from 1992 to 1997 showed that targeting groups whose activities and settings expose them to a higher risk of HIV/AIDS can contribute significantly to halting the spread of the epidemic.

FHI and the 22 nongovernmental organizations (NGOs) and other local and international groups that are its partners in IMPACT/Kenya have used such lessons to design a targeted intervention strategy for the program. The design combines intensive prevention and care activities in selected regions with activities at the national level to help create an environment that supports sustained behavior change.

To have the greatest possible impact on HIV with the resources available, the IMPACT design focuses on eleven "priority communities" in three provinces—Western, Rift Valley and Mombasa—which were selected based on HIV prevalence, the presence of high-risk situations and settings, and programmatic needs and gaps. The high population densities in the chosen communities further justify the investment.

The largely rural Western Province has a population density six times the national average and high rates of HIV infection among those tested in prevalence studies. In the town of Busia on the Kenya-Uganda border, for example, prevalence among women at antenatal clinics has approached or exceeded 30 percent. Before FHI/IMPACT started activities in this province, the region had few HIV prevention programs.

More than one out of four adults are estimated to be infected with HIV in Nakuru, Kenya's third largest city and capital of Rift Valley Province. Nakuru is surrounded by small towns dominated by agricultural industries, military bases and truck stops, where the practice of high-risk behaviors has fuelled the epidemic.

In the coastal town of Mombasa, a major port, numerous industries and tourism have attracted Kenya's highest immigrant worker population after that of the capital city of Nairobi. Some 2,000

women serve commercial sex clients in Mombasa's port, rail, trucking and tourism businesses, and half of all the sex workers tested in prevalence surveys have tested HIV-positive.

Five priority communities in these three provinces were originally targeted for IMPACT program interventions. Additional funding from the U.S. government's Leadership and Investment in Fighting an Epidemic (LIFE) Initiative enabled IMPACT/Kenya to expand from five to 11 communities. It also gave the program, whose original mandate had primarily been HIV prevention, an opportunity to help people cope with the impact of HIV/AIDS on their families and communities.

Collaboration and Participation To facilitate collaboration among the IMPACT partners, FHI established field offices in Mombasa and Nakuru. FHI also holds monthly meetings that bring together an "implementation team" of representatives of all the IMPACT partners in each province to review progress, plan future activities, and discuss opportunities and constraints. These kinds of regular interaction have helped the program achieve a unique degree of collaboration, according to Dr. Elizabeth Ngugi, co-director of the University of Nairobi's Strengthening Sexually Transmitted Disease (STD)/AIDS Control in Kenya Project. Under IMPACT, University of Nairobi staff members help train clinicians at clinics

managed by the Family Planning Association of Kenya and collaborate with Arnet Waves Communications on community outreach.

"Each one of the implementing partners is contributing an aspect in the prevention-to-care continuum, and we all feel as members of a family," Dr. Ngugi said.

Community Involvement In all the priority communities, FHI/IMPACT promotes behavior change and a more supportive social environment for reducing HIV risk. The program also strengthens or helps establish the services necessary to support behavior change, such as accessible, effective diagnosis and treatment of sexually transmitted infections (STIs).

Interpersonal approaches are at the core of IMPACT's intervention strategy. Peer education in the priority communities targets sex workers, men at workplaces, adult women in low-income neighborhoods, and students. Outreach through performances by youth drama groups is primarily aimed at youth, but also speaks to parents and other community members.

"These interventions make it possible to bring HIV and AIDS into daily living room discussions among families in the priority communities," says Peter Mwarogo, field operations manager for FHI/Kenya. "The man gets the same message from his peers at the workplace, so does his wife from neighbor-

hood peer educators, and the children from the school and the youth theater outreaches. Issues brought out through these various sources can trigger discussions at dinner time, thus making HIV/AIDS an everyday agenda in the home."

Peer educators across the priority communities initially receive one week of training, which is updated at regular meetings with IMPACT field coordinators. During the meetings, participants discuss the questions they've received and how to respond to them. They also develop and practice the use of participatory approaches to peer education.

The standard curriculum for peer educators emphasizes interpersonal communication skills and participatory techniques. For example, "picture codes," or illustrations depicting various risk situations, are used to provoke spirited discussion and individual and group reflection. Participatory games capture audiences' attention and make learning fun.

"One does not feel like you are put in a corner to receive education," observed Stephen Mukare, who has participated in peer education sessions at the Kenya Ports Authority. "We contribute as much as we receive the information."

Ask Me FHI and its partners knew that IMPACT needed an innovative communication strategy to help move Kenyans beyond aware-

"These interventions make it possible to bring HIV and AIDS into daily living room discussions among families."

ness of HIV/AIDS to action. "It is well known that the usual messages about HIV and AIDS have perhaps outlived their shelf life and lost their edge and power to trigger reflection and behavior change," said C.Y. Gopinath, creative director for PATH/Kenya.

The theme of the IMPACT strategy, executed by PATH and the rest of the partners in all sites, is "question your relations and take charge of your life."

"AIDS is a consequence of fractured relations, just like violence and other social problems," Gopinath explained. "This strategy encourages inquiry into the quality of relationships that dominate within communities—between husband and wife, young man and woman, CSW [commercial sex worker] and her client, infected and uninfected."

Such inquiry, captured in the Kiswahili slogan "Niulize" ("Ask me"), is intended to create a more positive view of what these relationships could be, and thus lay the foundation for optimism and change. Peer educators and outreach workers provide information in response to questions from community members, and the issues raised become more complex as people's ability to reflect on their own situations deepens.

The concerns and themes that arise within the communities will be amplified to a wider public, mainly through a 30-minute interactive radio show that will be broadcast nationwide. The program will include a soap opera called Pendo's Story, a panel discussion, news, interviews and song.

Reaching Youth Discussions about sexual relationships and the Kenyan HIV/AIDS epidemic often turn to the relations between girls or young women and older men. "In Kenya, like in many other African countries, older men are targeting younger girls who they believe are 'clean,'" said Theophil Orangi, a teacher and Girl Guide leader. "It is attitudes such as these that have led to an increase in HIV among girls."

Studies in Kenya have identified youth, and particularly girls, to be at high risk of HIV infection. National statistics indicate that the highest HIV prevalence rates are found among women ages 20 to 24 and men ages 30 to 39. Studies from Nyanza Province show that 22 percent of young women in the 15- to 19-year age group are already infected with HIV, compared with just 4 percent of their male counterparts.¹

One IMPACT project uses the national network of the Girl Guides to bring HIV/AIDS prevention education to girls. This



As caregivers, widows and people affected by the virus, women often shoulder much of the burden of HIV/AIDS.

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peer education initiative, carried out by the Kenya Girl Guides Association with technical assistance from IMPACT, includes contests and a merit badge that Girl Guides can earn through work and study.

"Our youth usually influence each other to do negative things," said Margaret Ochieng of the Kenya Girl Guides Association in Mumias. "In this case, we are empowering the youth to influence each other in a positive way."

Young people also influence their peers through the popular theater program run by Artnet Waves Communications. Artnet

trains members of local youth groups in basic theater production skills, and other IMPACT partners educate them about HIV/AIDS so they can stage short performances with HIV/AIDS messages.

Schools are also part of the effort to reach youth with potential lifesaving information and support. FHI/IMPACT is working with the Centre for British Teachers (CfBT), which has enlisted teams of parents and teachers from 100 schools in Nakuru to determine how to integrate HIV/AIDS messages into subjects such as home science, music, languages, arts and crafts, and drama.

Empowering Women In its work with sex workers, FHI/IMPACT has adopted the model developed by the STD Project of the University of Nairobi in Nairobi and Nakuru. By mobilizing sex workers to use condoms, seek prompt treatment for STDs and form support groups through which they were empowered with negotiating skills, the project helped the women take measures to protect themselves from HIV. As a result, the annual incidence of HIV among 4,000 sex workers in the project sites dropped from nearly 50 percent in 1987 to approximately 10 percent in 1997.

The project paid dividends for other community members: a 15 percent decline in the number of pregnant women testing positive for HIV. This result illustrates how interventions targeting groups at high risk—a common strategy in areas with low HIV prevalence—can also have a dramatic impact in high-prevalence settings.

"By reducing STD in sex workers, we are reducing STD in men and, by extension, we are reducing STD in the men's spouses," said Dr. Ngugi.

FHI/IMPACT is expanding the work of the STD Project to all of its priority community sites, involving other organizations in the effort, and incorporating more participatory methods. Laura Wangari, a project coordinator attached to the International Centre for Reproductive Health, which is an affiliate of the

University of Ghent in Belgium and an IMPACT partner in Mombasa, says the approach is proving effective.

"Many of the women did not believe in condoms and some were initially hostile when approached," she said. "But once the peer educators were trained and starting using condoms, the demand for condoms shot up."

Rose Wambua, a sex worker in Mombasa, appreciates the negotiating skills she has learned and the caring attitudes of program staff. "In a community with a lot of negative attitudes towards female sex workers, the program has made us feel someone values us as human beings and is interested in our health and welfare," she said.

Still, Wambua notes, it takes time and patience to convince men to use condoms. Sometimes solidarity with other women helps. "In some groups, the women have blacklisted clients who still insist on not using condoms," Wangari reported.

Involving Workers and Employers Members of another important audience—men—are reached on the job. In Mombasa, for example, IMPACT supports four large workplace HIV/AIDS projects. As part of one of these projects, 200 peer educators hold weekly meetings and informal talks with their coworkers at the Kenya Ports Authority (KPA), which has about 7,000 mostly male employees.

Qualitative evaluation suggests that such workplace programs are beginning to affect norms of social behavior and that they have stimulated demand for HIV prevention services such as STI treatment and condom social marketing. Most programs, however, have been donor-driven, and only a few businesses are directly funding HIV/AIDS prevention activities.

In Western Province, the Mumias Sugar Company is emerging as a model of what companies can do. During a recent launch of the IMPACT program in Mumias, the company's chief executive officer, Errol Johnstone, announced that the organization would set aside funds for a comprehensive HIV/AIDS program and request technical assistance from FHI.

To encourage other companies to respond as Mumias Sugar Company has, FHI is collaborating with the Regional AIDS Training Network at the University of Nairobi to develop a package of HIV prevention services that employers can purchase. FHI/IMPACT is also working at the national level to heighten management and employee awareness of the need for workplace-based interventions. The aim is to institutionalize sustainable, high-quality workplace HIV/AIDS programs funded primarily by employers.

"We know many companies are trying to find ways to address the problem," said McWilliam. "We'd like to help them find ways to assist their workers in prevention, care and support for HIV and AIDS."

Linking Prevention and Care Voluntary HIV counseling and testing (VCT) is seen as the linchpin in the prevention-to-care continuum that local organizations and communities are building with the help of FHI/IMPACT. Through a referral network of peer educators, field coordinators, counselors, healthcare staff and community caregivers, HIV VCT services will help link prevention efforts with the newer care and support interventions made possible by the LIFE Initiative.

HIV VCT can be an effective behavior change intervention in its own right, as the findings of a multicenter randomized study conducted in Kenya, Tanzania and Trinidad confirmed.² Mary, the young HIV-positive widow from Western Kenya Province, knows this link between VCT and prevention all too well. An active volunteer in the Society of Women Against AIDS in Kenya (SWAK), one of IMPACT's partners, she has taken her role in HIV prevention very seriously since learning of her status.

"Men sometimes try to seduce me, but I resist their advances," Mary said. "If I was careless, I would have spread the disease to many people."

Mary also knows how important the psychological support she received from Kenyatta Hospital counselors was in giving her the will to survive. She believes that better access to such services is essential for reducing the stigma associated with HIV/AIDS.

"Counseling, especially in rural areas, should be increased,"

she said. "This will help people come out in the open and speak about AIDS."

Assessments of HIV VCT services in Kenya have shown that few services are available, and most sites offering counseling and testing provide poor service. Confidentiality may not be guaranteed, the quality

of counseling is variable, and linkages between HIV VCT and HIV/AIDS care and support services are often non-existent. One study conducted by FHI and the Population Council found only one site in Nairobi offering walk-in counseling and testing services in 1999.³

FHI/IMPACT's vision is to bring quality HIV VCT services to the community. The program is working with a variety of partners to establish voluntary counseling and testing centers in each of the priority communities, usually by adapting and equipping existing health centers to provide such services. Lab technicians are trained in HIV testing and quality assurance, and counselors receive training in pre- and post-test counseling.

LIFE Opportunities VCT center staff will refer HIV-positive clients to sources of AIDS care, psychological and social support, and diagnosis and treatment of tuberculosis and other opportunistic infections. LIFE Initiative funding will enable FHI/IMPACT

"It is well known that the usual messages about HIV and AIDS have perhaps outlived their shelf life."

to complete the continuum from prevention through care by working with Kenyan health services, NGOs and communities to improve such services.

For example, FHI/IMPACT is collaborating with the public health system to strengthen the capacity of medical facilities to offer diagnosis and treatment of TB, which has reached epidemic proportions in communities with high rates of HIV. Even in countries with successful TB control programs like Kenya's, AIDS-related TB is overwhelming existing resources. As a result of rising HIV infections, Kenya has experienced a 600 percent increase in its TB caseload over the past 11 years.

FHI/IMPACT will also help forge an often missing link in the continuum of care by preparing a number of health centers to serve as HIV clinical care centers. These centers will offer much needed medical support to the family members and volunteers who provide home-based care to a growing number of people living with HIV/AIDS.

FHI is working with ICROSS (International Community for Relief of Starvation and Suffering), a local NGO, and Kenya's district AIDS committees to improve home-based care. Collaboration with district AIDS committees enhances sustainability because staff salaries are paid by the Kenyan government.

The district AIDS committees will form home care teams of government health personnel and community volunteers to provide individualized care and support services to HIV/AIDS-affected households. The services offered may include counseling, nutrition, infection prevention and palliative care, depending on the needs identified by families affected by HIV/AIDS in participatory assessments.

Once the ICROSS home care program is underway, a similar participatory process will help mobilize communities to support orphans and other vulnerable children. Peer educators, support group members, home care teams and other community members will be involved in identifying children in need of support and the community resources available to support them.

A Beginning Before they began implementing IMPACT projects, the partner NGOs mapped out their communities together, highlighting areas where HIV risk behavior was prevalent, as well as existing prevention and care services in their communities. Mapping the communities and dividing them into zones assigned to different field coordinators and peer educators helped the



A young man receives counseling and instruction on condom use after giving blood for a voluntary HIV test at a Kenyan clinic.

GIACOMO PIROZZI/PANOS PICTURES

IMPACT partners ensure that their communities were covered and that high-risk areas were adequately targeted by interventions.

"With this intensity, we are covering *everyone* in each of our priority communities," explained Stella Kilalo, a field coordinator for the Mkomani Clinic Society, an IMPACT partner in Mombasa.

The experience of Mariam Abdalla, a resident of the IMPACT priority site of Kisauni, illustrates how such intensive community-based prevention and care activities can have a pervasive influence.

The wife of a driver at Bamburi Portland cement factory, one of the IMPACT workplace sites, Abdalla says these days she discusses AIDS issues with her family and is impressed that her daughter, son and husband are equally well informed. Her neighbor, Rukia Mohamed, has been trained as a community caregiver by another USAID partner, Pathfinder International, and Abdalla has referred people to her.

Of late, Abdalla says, the health workers at the Kisauni clinic are very friendly. Every time she visits the clinic, the providers talk to her about HIV/AIDS and STIs. Abdalla has not yet decided to go for HIV testing but thinks she will as soon as the services are introduced at the Kisauni health center. Only time will tell.

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Breaking the Silence in Nigeria: An Appeal to Presidents

SPEECH BY JOHN IBEKWE

A courageous speech by a Nigerian man living with HIV/AIDS—and the response from Nigeria's President and the visiting President of the United States—made a profound impression on a nation mired in denial of an epidemic that has already spread to 5 percent of its adult population.

John Ibekwe of Onitsha, Nigeria, never thought he'd meet a president. But on August 27, 2000, in the Nigerian capital of Abuja, he had the opportunity to tell his story to the leaders of the Federal Republic of Nigeria and the United States. A program officer with the Humane Health Organization, which is a partner in the Family Health International (FHI) Implementing AIDS Prevention and Care (IMPACT) program in Nigeria, Ibekwe was one of four speakers at an event organized for U.S. President Bill

Clinton's visit to Nigeria. Ibekwe also introduced President Clinton. Tayo Akinmuwagun, a volunteer peer health educator with the Environmental Development and Family Health Organization, a youth-focused NGO that is also a partner in the FHI/IMPACT program, introduced Nigerian President Olusegun Obasanjo.

As President Obasanjo, President Clinton and an audience of about 1,200 health workers and community members listened, Ibekwe told of the discrimination he faces as a person living with HIV. He urged both presidents to serve as powerful advocates against the pervasive stigma and denial associated with the virus.

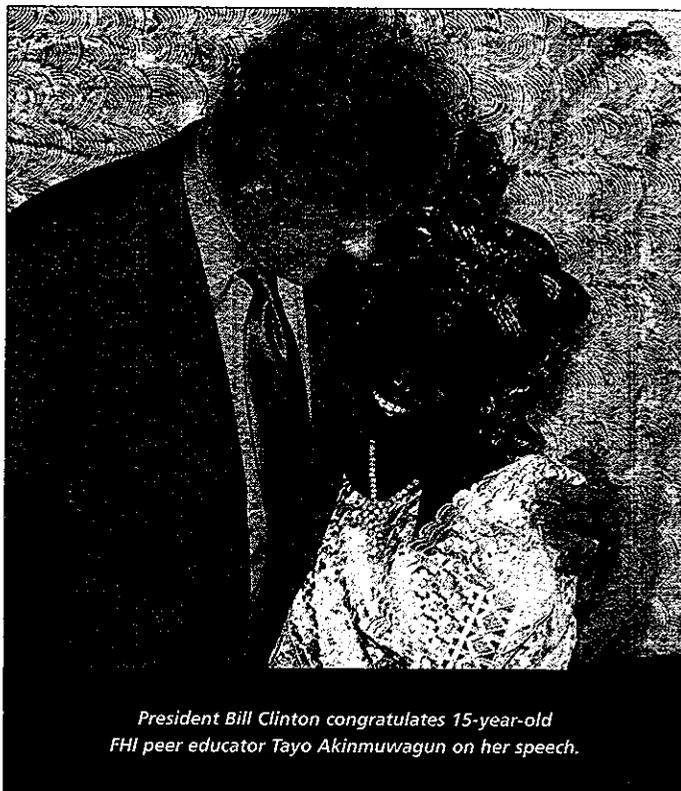
Almost two weeks later, at a reception for African leaders assembled in New York City for the United Nations Millennium Summit, President Clinton spoke with emotion about Ibekwe's presentation, calling it "one of the most moving experiences I have had as a president."

"I have been through a lot of interesting and profoundly emotional experiences the last eight years," he added. "But one of the most moving things that's happened to me happened when

we were just in Nigeria and President Obasanjo and I went to this event in an auditorium with a lot of people to talk about what they were doing in Nigeria to try to prevent AIDS."

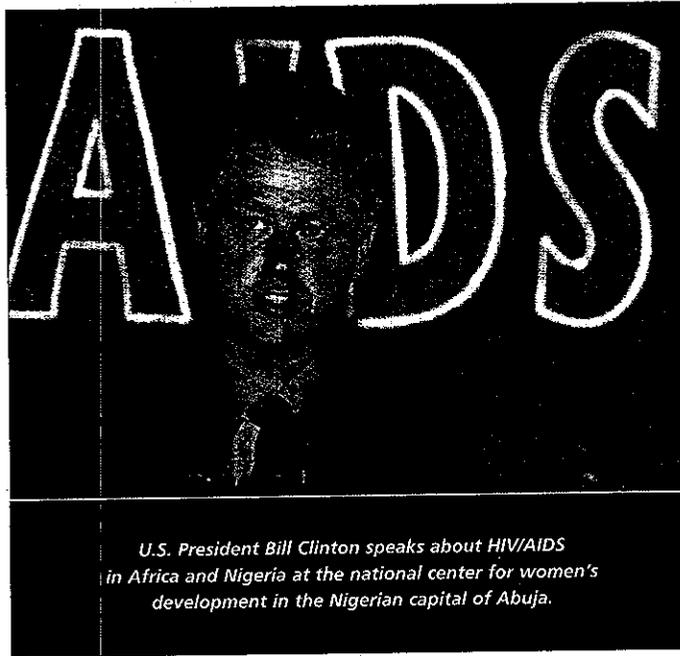
President Clinton recounted Ibekwe's story and told his audience that at the end of the presentation, President Obasanjo had embraced Ibekwe's wife, Angela, who is also HIV-positive, in front of hundreds of people. "It was all over the press in Nigeria the next day," President Clinton added. "It changed the whole thinking of a nation about how to approach this disease—to treat the disease as the enemy, but not the people who are gripped with it. It was an amazing encounter."

—Kathleen Henry



President Bill Clinton congratulates 15-year-old FHI peer educator Tayo Akinmuwagun on her speech.

REUTERS



U.S. President Bill Clinton speaks about HIV/AIDS in Africa and Nigeria at the national center for women's development in the Nigerian capital of Abuja.

TIM SLOAN/AGENCE FRANCE PRESSE

"Mr. Presidents, I am an adult living with AIDS. I used to think there was no hope for those of us living with HIV/AIDS in this country. But my perception of the future has changed. For the first time in this country, we have a president who has openly acknowledged that AIDS is a problem and has decided to lead the fight against it.

I wish to applaud the dedication of President Obasanjo in the fight against AIDS in Nigeria. But the size of the problem in Nigeria is huge and looks suffocating.

Distinguished guests, this is my story. My wife and I lived together from January of 1995 after our traditional marriage and got a date in April of that same year for our church wedding. But part of the conditions to be met before marriage in the Catholic Church in Onitsha, where we stay, was an HIV antibody test. Without pre-test counseling, my wife and I took the HIV antibody test, and the result was positive for my wife and negative for me.

First, the church announced the revocation of the wedding. When we insisted, our parents were invited. The priest asked our parents if they knew our serostatus. They said yes. The church took time to explain the implications to our parents, but they still supported the marriage. The church thereafter agreed to wed us.

After the wedding, we became close to the archbishop and all the reverend fathers involved. The archbishop referred us to an Argentine doctor, Suzi Coddazi, who was then implementing Family Health International's community home-based care project in Onitsha, funded by the United States Agency for International Development. Our situation improved with the counseling and home visits by outreach workers from the project. I am today a program officer of the care and support project.

In August 1995, my wife was one of those offered an American visa through the lottery. We were then referred to St. Nicholas Hospital in Lagos by the American Embassy for medical tests that included the HIV antibody test. My wife tested positive again. Here, I tested positive for the first time. We presented our documents at the American Embassy and were informed that we could not be given the visa on the basis of our serostatus.

Soon after this, a national meeting of people living with HIV/AIDS was convened in Ibadan. It was at this meeting that I was elected national president. I granted press interviews, which

I learnt more about the possibility of preventing mother-to-child transmission of HIV.

I saved enough money from my food allowance for the conference to buy antiretrovirals for my wife and the baby. In Onitsha, we had a long, drawn-out battle with the hospital staff to provide my wife care. They abandoned her because of her HIV status. It was discouraging, but we persisted. My wife had a caesarian section to further protect the baby. The baby was delivered October 8, 1998. My wife is here with me today, and our baby, at 18 months plus, is still seronegative.

Mr. Presidents, the problems of people living with HIV/AIDS are indeed basic and fundamental. While a lot can be achieved with effective community-based care for people living with HIV/AIDS, this level of care is not readily available. Protecting people living with HIV/AIDS from retrenchment and dismissal from work when diagnosed will go a long way to keep hope alive.

Mr. Presidents, I do not wish to bore you with many requests but only to say that we request your support for advocacy to

break the silence and denial at different levels of decision making. We request your support in the area of advocacy to discourage stigma and halt discrimination. And drugs that will prevent children from being infected in pregnancy should be made available, affordable and easily accessible.

"I used to think there was no hope for those of us living with HIV/AIDS in this country."

Mr. President of the United States, you can do something today that will change the entire course of the AIDS pandemic in our world. With you as an advocate on our side, governments in Africa will do more than they are currently doing. Just as you have touched many homes and hearts in Africa with your good works in the area of health, I call on you today to touch the hearts of all ailing persons living with HIV/AIDS with your soothing hands. The war against AIDS can be won if we all come together."



Targeting Tuberculosis in Countries with High HIV Infection Rates

By Mukadi Ya Diul

Tuberculosis (TB) is one of the leading causes of death and illness among people living with AIDS in developing countries. More than one-third of people living with HIV/AIDS worldwide are also infected with *Mycobacterium tuberculosis* (the TB bacillus), and 40 percent to 60 percent of them will develop tuberculosis.¹

The two infections have been closely linked since the beginning of the HIV/AIDS pandemic in the early 1980s, when AIDS patients living in TB endemic areas began to present with disseminated tuberculosis, along with other opportunistic infections. Today we know that this relationship is mutually advantageous. HIV contributes to the reactivation of latent TB infection and makes individuals with recent TB infections more susceptible to rapid progression to active disease. Active TB, in turn, may accelerate the course of HIV infection.

Targeting TB in areas with high HIV infection rates is critical because tuberculosis is one of the few infectious diseases fueled by the HIV epidemic that does not remain confined to people infected with HIV. It is also one of the first opportunistic infections to appear in those who are infected with HIV, providing a warning sign that offers opportunities for early intervention. Yet while HIV and TB work together in deadly partnership, most countries continue to address the two epidemics through separate—and therefore less effective—programs.

A Fragmented Approach

The priority of TB control programs remains implementing the strategy called DOTS (directly observed treatment, short course), which has been promoted since the World Health Organization (WHO) declared tuberculosis infection a global emergency in 1993. The goal of DOTS is to detect 70 percent of all sputum-smear-positive TB cases and to cure 80 percent of them through passive detection and directly observed treatment. This means using sputum smear microscopy to

identify infectious TB cases among patients seeking treatment, providing a standardized treatment regimen of six to eight months, and ensuring that someone observes the patient taking the drug, at least during the initial two months. Successful implementation of DOTS requires an efficient system for monitoring and evaluation, regular and uninterrupted supply of all essential anti-TB drugs, and a strong government commitment to sustained TB control activities.

Many TB program managers have assumed that DOTS alone would control TB, regardless of the HIV epidemic. This has not proved to be the case. In fact, since their HIV epidemics began, many countries that had successfully implemented DOTS have been struggling to control TB. In one such country—Tanzania—a DOTS program that is considered a model reported a 160 percent increase in the number of TB cases between 1984 and 1993, despite reported cure rates of 80 percent. During that period, an estimated 24 percent of all new smear-positive TB cases were attributable to HIV.²

Botswana is another example. After introducing the DOTS strategy in 1986, the country's TB control program recorded a decrease in the incidence of TB cases throughout the 1980s. However, this trend was reversed in the early 1990s. Today Botswana has one of the highest TB incidence rates in the world.³ Similar trends in the number of TB cases have been reported in other countries in sub-Saharan Africa and in selected areas in Southeast Asia, such as the province of Chiang Rai in northern Thailand.⁴

In addition to increasing the number of TB cases, HIV epidemics have also had an impact on the performance of TB control programs. Countries with high HIV rates, where more than half of TB patients are infected with HIV, are reporting increasing mortality among TB patients. Malawi, for example, reported that in 1996, 21 percent of smear-positive TB patients died during the course of their treatment. With

such high case fatality rates, these countries cannot reach the DOTS goal of curing 80 percent of TB cases. High mortality rates among tuberculosis patients also threaten the reputations of TB programs, the morale of TB healthcare workers and the popular perception that TB is a curable disease.

While TB programs focus on implementing DOTS, the priority of HIV/AIDS programs is to prevent HIV transmission and mitigate the health, social and economic impact of the HIV epidemic. Most HIV/AIDS programs have left TB control to their countries' TB programs.

Many people living with HIV, however, do not have access to TB services. This may be because they do not want to reveal their HIV status outside the settings where they usually receive care and support services or because they do not have financial means to gain access to TB services.

The poor management of TB by HIV/AIDS services and increasing transmission of TB reflect the consequences of this fragmented approach to the dual epidemic. In countries with high HIV prevalence, HIV/AIDS and TB programs should be working together to support and strengthen the DOTS strategy and to address the needs of people living with HIV.

Strengthening DOTS

Five years after the introduction of DOTS, 119 of the 189 countries reporting to WHO were implementing this strategy. In 1998, only 17 percent of all estimated cases and 21 percent of estimated smear-positive TB cases were detected under the DOTS strategy. According to WHO's 2000 global TB report, TB treatment success with DOTS varies from 62 percent to 93 percent.⁵ In countries with an HIV prevalence of at least 10 percent in the general population, however, TB treatment success ranges from 58 percent to 73 percent and, on average, 19 percent of the patients die before completing treatment or are lost to follow-up.

In countries with low HIV prevalence, the DOTS strategy, when applied properly, has helped achieve high cure rates and limit the emergence of TB strains resistant to multiple drugs. In countries with high HIV prevalence, this strategy should be reinforced with innovative approaches to detecting TB cases and improving compliance with treatment.



SEAN SPRAGUE/IMPACT VISUALS

TB is a leading cause of death and illness among people with HIV/AIDS.

Improving case detection

Detecting infectious TB cases is critical in TB control. Early detection of infectious TB cases reduces the pool of infectious individuals in the community and therefore limits the transmission.

Under DOTS, TB programs rely on patients to present themselves to TB clinics for evaluation of their symptoms. This approach assumes that patients are knowledgeable of TB symptoms and that structural and cultural barriers to TB services do not exist. Unfortunately, that is not always the situation. WHO's 2000 global TB report clearly shows that 60 percent of the estimated 3.57 million cases of infectious TB in 1998 were not detected.⁵

The current strategy of TB control programs is to concentrate on increasing case detection only after a program has raised its cure or treatment success rate to around 80 percent. When programs do try to improve case detection, their impact is generally limited at best. This is because these efforts usually overlook the impact of cultural beliefs on healthcare-seeking behavior and do not always target (in their language or approaches) hard-to-reach populations.

Many studies are revealing the impact of cultural beliefs on healthcare-seeking behaviors. In Cambodia, for example, FHI's investigation of perceptions of cough found that people categorize coughs as different types and have a differ-



SEAN SPRAGUE/IMPACT VISUALS

A doctor examines a man with TB at a floating clinic in Cambodia.

ent approach to seeking a diagnosis for each type.⁶ A recently published study shows that in Thailand, many people with TB symptoms were reluctant to seek medical care because they feared being identified as AIDS patients.⁷

Efforts to improve TB case detection offer an opportunity to draw on experience in changing behavior for HIV prevention. TB control programs can work with HIV/AIDS programs to develop interventions and communication strategies to change healthcare-seeking behavior and ensure prompt and effective treatment of new cases.

TB case detection can also be improved by introducing active case-finding interventions. Such interventions can initially target selected groups, such as family members of HIV-positive TB patients, confined populations and people living in overcrowded settlements.

Encouraging treatment compliance

TB treatment is a key element in tuberculosis control. Adequate treatment not only cures the patient, but also reduces transmission, and thereby the number of new infections. But treatment of TB requires at least three different drugs, which should be taken for at least six months. Patients may, for many reasons and particularly when their TB symptoms disappear, opt to interrupt their treatment. Poor compliance with TB treatment is even more dangerous than no treatment because it may increase the risk of developing multi-drug-resistant TB.

TB programs must develop strategies and interventions to ensure that patients who start treatment will complete it. Programs can use formative research among healthcare workers, community members, patients who default on treatment and those who comply with treatment to identify reasons for poor compliance. Then, based on data from this research, they can develop interventions, such as staff training and patient education and support, to encourage patients to complete treatment. This is another area where TB control program might seek assistance from HIV/AIDS programs, which have been studying and applying principles of behavior change for many years.

Another strategy for addressing compliance is to involve others in monitoring TB treatment. The involvement of communities in TB care has contributed to increased treatment success rates in Peru, Haiti and Bangladesh. WHO has just completed eight pilot studies in six sub-Saharan African countries (Botswana, Kenya, Malawi, South Africa, Uganda and Zambia) in which community members were trained to supervise treatment and support TB patients throughout their treatment. Data from these projects indicate that involving community members in TB care is cost-effective and helps achieve higher cure rates.

Beyond DOTS

Most TB control programs in high HIV-prevalence countries do not address HIV, even though many of their patients may be infected with the virus. Services such as HIV/AIDS education and counseling and testing are not always available at TB service points.

In many countries, HIV information and education is provided in TB clinics as part of the general health education given to TB patients. But TB and HIV are usually presented separately, and the interaction between them is often ignored. In some areas, HIV is not mentioned at all because healthcare workers believe that providing HIV education at TB clinics would scare away patients. Sometimes healthcare workers are so poorly informed about HIV that they are uncomfortable talking about it with their patients. Such attitudes obviously contribute to fears about AIDS and to the existing stigma associated with HIV.

Providing HIV education to healthcare workers in TB clinics can build their confidence in their ability to discuss HIV with their patients. Regular HIV education can also empower patients and provide them with the skills they need to reduce the risk of acquiring or transmitting HIV. And, by filling gaps in HIV knowledge and dispelling misunderstandings about the disease, HIV education can help reduce the related stigma and discrimination. TB control programs can seek the assistance of HIV/AIDS programs in training TB clinics' healthcare staff and developing educational materials addressing TB and HIV.

Access to counseling and testing

Given the strong relationship between TB and HIV, TB patients should be given the opportunity to know their HIV status. Most of them are aware of the strong correlation between TB and HIV, and once the diagnosis of TB is made, many live with the anxiety of believing that they might be infected with HIV.

Knowledge of serostatus will alleviate anxiety for those who test negative for HIV and motivate them to adopt lifesaving skills. But even for a person who is infected with HIV, knowledge of his or her status is valuable. Such knowledge makes it possible to plan for the future and change one's behavior to protect others. It also makes HIV more visible in communities, contributing to the reduction of stigma. And even though antiretroviral therapy is not widely available in most countries, people living with HIV can benefit from basic healthcare services and early preventive treatment or diagnosis and treatment of opportunistic infections.

TB patients' access to voluntary HIV counseling and testing can be improved by introducing such services into TB clinics or by building strong referral mechanisms between TB clinics and existing HIV voluntary counseling and testing services. In both cases, TB clinics need to train healthcare workers in educating TB patients about HIV, inform TB patients about the availability of the service, and establish linkages between medical services and support groups within the community. If voluntary HIV counseling and testing services are being introduced into a TB clinic, clinic managers need to arrange for the training of counselors, nursing staff and laboratory technicians. They also need to develop

mechanisms for a regular supply of HIV testing kits and the referral of blood specimens and results between a laboratory and the clinic.

Managing HIV-related diseases

Health care workers in TB clinics generally know how to manage common, uncomplicated HIV-related illnesses. However, most non-industrialized countries do not have guidelines that would facilitate the management of HIV-infected TB patients and help healthcare workers decide when and where to refer patients. TB programs' proven experience in developing and disseminating TB control guidelines can be exploited by both TB and HIV/AIDS programs to establish guidelines on managing common, uncomplicated HIV-related illnesses. National tuberculosis control programs could build on existing TB training mechanisms to provide regular refresher training that keeps healthcare workers informed about new developments in the management of HIV-related disease.

Providing appropriate care to HIV-infected

HIV/AIDS programs can only benefit from collaborative efforts to treat and prevent the leading killer of people living with HIV.

patients will boost the credibility of healthcare workers in TB programs. Moreover, involving TB healthcare workers in the management of HIV-related disease offers another advantage: if highly active antiretroviral therapy (HAART) for HIV infection becomes more widely available, TB clinics could be used to offer directly observed HAART to TB patients who are also infected with HIV as well as others living with HIV/AIDS.

TB in HIV/AIDS Programs

In countries with high rates of HIV infection where TB is prevalent, HIV/AIDS programs can contribute to TB control programs in various ways. For example, most of the community-based organizations that provide care and support to people living with HIV/AIDS must care for people who are also infected with TB. However, an evalu-

ation by the WHO of the management of TB in HIV/AIDS community care schemes revealed that the quality of such care was generally poor.⁸

The WHO review clearly recognized that HIV/AIDS community care schemes could help improve TB care. HIV/AIDS community-based organizations can educate people living with HIV about TB, prompt early TB case detection, and facilitate access to appropriate TB diagnosis and treatment. The staff and volunteers of these organizations can be trained to conduct active case finding of TB, particularly among partners of TB patients infected with HIV. They can also assist in providing and monitoring TB treatment.

The only potential pitfall in enlisting HIV/AIDS community-based organizations as partners in TB control is the stigma associated with HIV. In areas where such stigma is particularly strong, for example, TB patients may decline to be supervised by a member of an HIV/AIDS organization.

Preventing TB

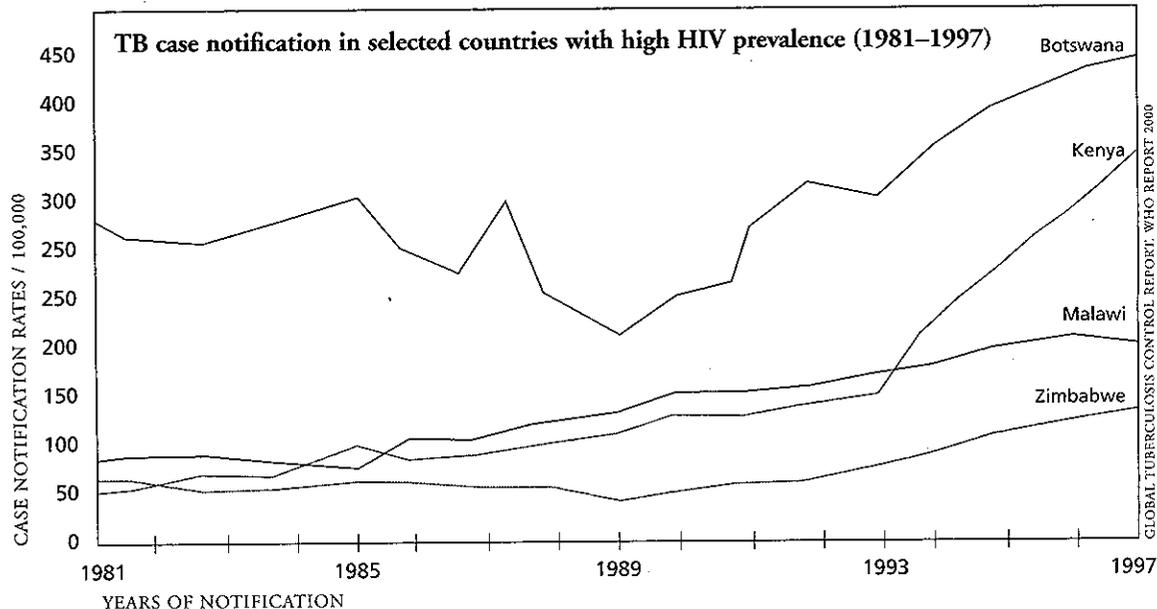
TB preventive therapy—which is the use of a simple regimen (usually isoniazid for at least six months) to prevent the development of active TB disease in a person known or likely to be infected with TB bacilli—is an effective means of preventing TB in people living with HIV/AIDS and therefore may reduce the TB burden in a community. The WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS) recommend that TB preventive therapy be given as part of a

package of care for people living with HIV/AIDS.⁹ However, care must be taken not to drain limited resources from TB control program activities, where diagnosis, treatment and cure of smear-positive cases must remain the priority. In addition, this TB preventive strategy requires identification of people who are infected with HIV. For both reasons, HIV voluntary counseling and testing centers may be an ideal site for such programs.

Implementation of a TB prevention intervention requires strong commitment from and collaboration between both the TB and HIV programs. Before implementation, TB programs should provide training in TB symptom recognition, diagnosis and treatment, exclusion of active TB, drug supply, treatment monitoring and diagnosis of active TB. Each HIV voluntary counseling and testing center participating in the program should have a clear plan for excluding active TB (systematic symptom evaluation for all HIV-infected patients or a clear referral mechanism to TB diagnostic services), and TB and HIV/AIDS programs should design a plan for monitoring and evaluating treatment. Such interventions could be coupled with other preventive therapies, such as cotrimoxazole (Bactrim) to prevent opportunistic infections.

Conclusion

TB program managers need to understand that there are more benefits than disadvantages to introducing HIV/AIDS services in TB clinics and responding to the needs of TB patients who are living with HIV. In fact, TB programs in countries



with high HIV prevalence will not succeed without addressing HIV/AIDS. HIV/AIDS programs, in turn, can only benefit from collaborative efforts to treat and prevent the leading killer of people living with HIV. In countries with high rates of HIV infection, HIV and TB control programs need each other, and they must work together to reduce transmission of both infections and to improve care and support for all their clients.

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Integrating TB and HIV/AIDS Services: FHI Examples from the Field

In Kenya and Rwanda, FHI is working closely with the national TB and HIV/AIDS programs to implement integrated TB and HIV interventions. These interventions consist of:

- Increasing TB patients' access to HIV prevention education and voluntary counseling and testing.
- Active case finding of TB cases among partners

In Cambodia, FHI, in collaboration with the Gorgas Memorial Institute/University of Alabama, is developing a TB pilot project in Phnom Penh serving squatters, prisoners, people living with HIV/AIDS and their families, and other hard-to-reach populations in this urban setting. The project includes:

- A study of the prevalence of active TB among



Helping Men Make A Difference in HIV Prevention

BY JOHN-MANUEL ANDRIOTE

Efforts to involve both men and women in HIV prevention have shown that containing the spread of the virus will require fundamental changes in societies' expectations of men and women.

What makes a man?

As simple as the question may be, its varied, complex answers are the keys to effective HIV prevention throughout the world.

Worldwide, women bear the greatest burdens of AIDS. They are physiologically more vulnerable to HIV. There are more HIV-infected women than men. And women typically provide the most care to others who are sick with AIDS-related illnesses.

But it is men who drive the HIV/AIDS epidemic. Whether they are infected via sex or drug use—the most common ways men are infected—men are the vehicles through which HIV is transmitted to both men and women.

Even the best prevention campaigns targeting women are rendered ineffective when male partners refuse to change their risk behaviors or use condoms. More often than not, men's behaviors and refusal to change are rooted in their own beliefs and society's expectations about what it means to be a man.

In Asia, for example, there is "the basic double standard between men and women," said Pratin Dhamarak, regional program manager of the Family Health International (FHI) Asia Regional Office in Bangkok, Thailand. "Men are supposed to be experienced and know what to do in regard to sex," she explained, "while women are supposed to be innocent and submissive."

In other cultures, too, there are long-held ideas about what being a man means that contribute to the spread of HIV by, for example, viewing condoms as "unmanly." Women are often unable to protect themselves against HIV because their culture tells them they must comply with a man's wishes.

And HIV continues to spread. The Joint United Nations Programme on AIDS (UNAIDS) estimates that 4.7 million adults throughout the world became infected with HIV in 1999, with new infections almost equally divided between men (2.4 million) and women (2.3 million). Of the 33 million adults believed to be living with HIV or AIDS, 17.3 million are men.

Men Make a Difference In recognition of the role men play in virtually every case of sexual transmission of HIV, FHI supports many prevention projects around the world that specifically target men.

The work of these projects will be in the spotlight on December 1—World AIDS Day 2000—because this year's theme is "Men Make a Difference." It is also the theme of a two-year campaign, launched by UNAIDS in March 2000, focusing on the role of men in the HIV/AIDS epidemic. The campaign's objectives include motivating

men and women to talk openly about sex, drug use and HIV/AIDS and encouraging men to take care of themselves, their partners and their families.

Programs aimed at men seek to build connections with men in places where they come together for work or to socialize with one another. Often men who travel or are separated from their families or communities for extended periods gather in border or port cities where there are ample opportunities to contract or spread HIV—and to carry it home. For this reason, a number of FHI-supported prevention projects focus on these "mobile men," such as truck drivers, policemen, fishermen, taxi drivers and migrant workers.

Even the best prevention campaigns targeting women are rendered ineffective when male partners refuse to change their risk behaviors or use condoms.

A "Condom Tunnel" in Vietnam A full day's travel by air and car from Hanoi is Can Tho. Traffic—mainly motorbikes—moves slowly along a stretch of highway lined by small brothels. In an initiative dubbed "the condom tunnel" by FHI's Implementing AIDS Prevention and Care (IMPACT) program in Vietnam, a series of billboards and banners with condom use messages will be placed strategically along both sides of the two kilometers of highway at this "hot spot."

"Once the client hops off the motorbike and parks it, he will be faced with more posters or possibly a leaflet from the parking attendant," explained Donna Flanagan, FHI's resident advisor in Vietnam. "Inside the bar-restaurant-brothels, the men find similar messages on the beer mats, wall posters and over the sound system." Besides the condom messages, teams of dramatists will offer comedy skits about subjects such as the challenges of men, women, sex and condoms.

The condom tunnel and street dramas are only two components of an overall men's campaign under the IMPACT program in Vietnam, which is funded by the United States Agency for International Development (USAID). Peer education in factories is another component. Then there are the six contests for such titles as "Mr. Great Farmer," "Mr. Great University Student" and "Mr. Great Civil Servant."

The idea is a bit like a beauty pageant, explains Flanagan, "in which the guys will be judged on a number of things—one of which is their knowledge of and concern about their own health and that of their family." There will be "a lot of TV exposure for the winners," she added.

The men's campaign was designed to complement an IMPACT project that includes a new women's health club for sex workers in Can Tho. "No matter how we strive to help women develop self-esteem and sexual negotiation skills, they are nevertheless the weaker, non-paying partners in commercial sex," Flanagan said. "Putting the entire burden of condom negotiation on them is just adding one more chore to their already difficult lives."

Cambodian Seafarers in Thailand In Rayong, a port city on the east coast of Thailand, some 40,000 Cambodian seafarers work in the fishing industry—despite the government's official quota of 3,500 foreign workers for the industry. More than 90 percent of the Cambodians working in the port are illegal immigrants who pay up to \$US 90 to agents who recruit them from their villages.

Men with limited education and without documents such as passports and visas can often find jobs as fishermen. The adventure attracts young men, but the work is hard and full of physical risks. For these reasons, Dhamarak says, "when fishermen get paid, they

want to have a good time, spending money on drinks and sex."

Of course alcohol and condom use are often incompatible. But also undermining efforts to prevent these fishermen from contracting or spreading HIV is a low sense of self-worth. "Some men say their life is full of risk anyway," Dhamarak explained. "They don't know when they are going to die or get thrown overboard—so why be afraid of AIDS?"

Preliminary focus group discussions with Cambodian seafarers revealed the men's limited knowledge of HIV/AIDS. About 60 percent of the participants reported engaging in commercial sex. Although most of them said they did not use condoms, they did not perceive themselves to be at risk for sexually transmitted infections (STIs), including HIV.

Limited access to condoms is also a problem. Language barriers make it difficult to buy condoms, and the "freelance" sex workers these men frequent (as opposed to those who work out of brothels) often do not carry condoms.

Prey Veng Province, with nearly 1 million residents and among

Cambodia's most impoverished regions, is one of the "source communities" from which migrant Cambodian seafarers working in Thailand originate. A 1998 survey of sex workers in Prey Veng found an HIV prevalence rate of 34 percent—the second highest in the country—among "indirect" sex workers (who work in entertainment establishments or as

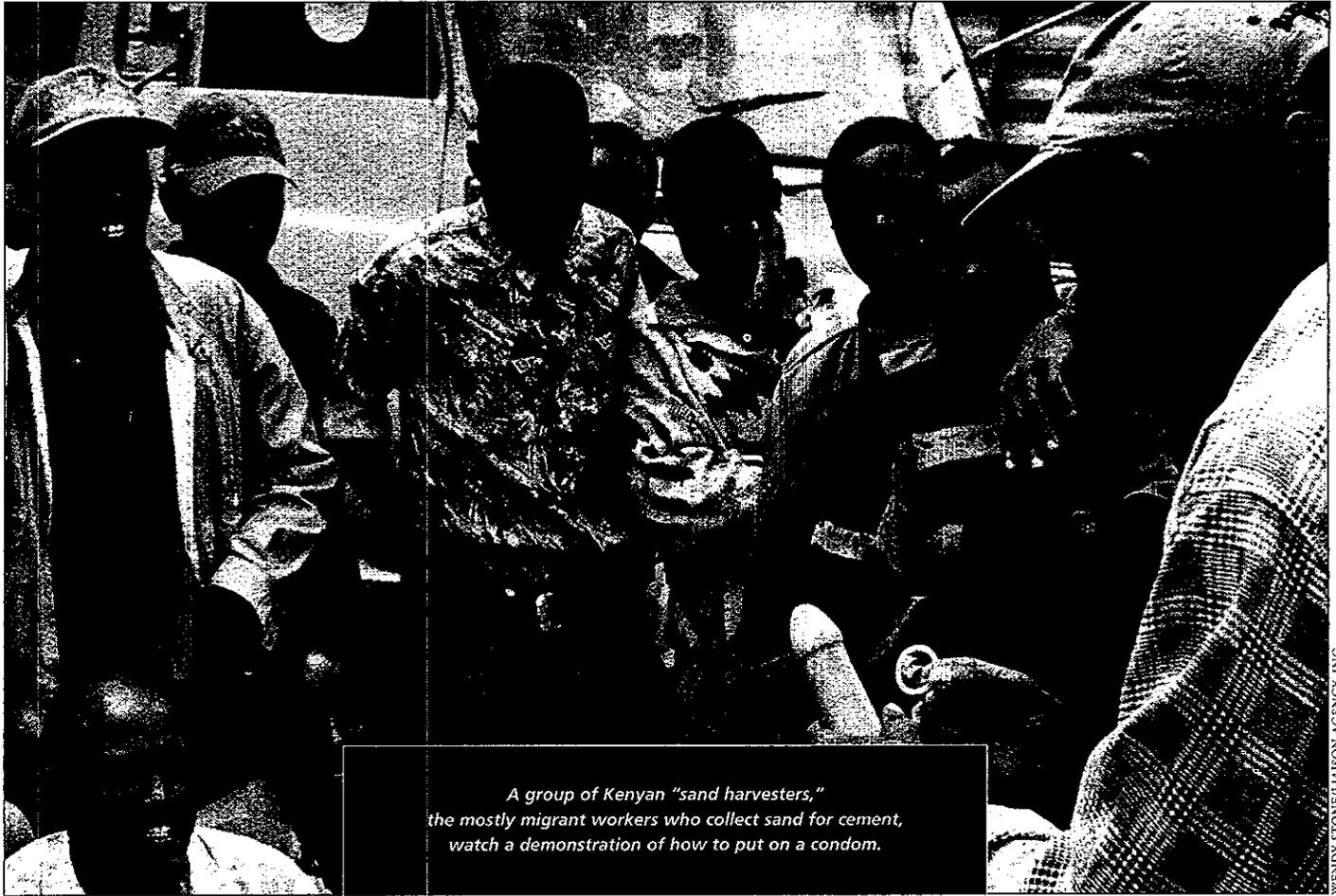
beer promoters) and 29 percent among "direct," usually brothel-based, sex workers.

A new FHI project funded by USAID's Asia Near East Bureau is providing simultaneous cross-border HIV/AIDS interventions for Cambodian seafarers in Rayong and their families in Prey Veng. In Cambodia, a team operating under the Provincial AIDS Committee of Prey Veng will identify specific villages and families of seafarers working in Rayong. They will offer reproductive health education and HIV/AIDS counseling to families of migrants in the source communities. For those already ill with AIDS, home care services will be organized to strengthen existing health resources in the community.

In Rayong, mixed Thai-Cambodian teams will conduct outreach education, working within social networks and with government and private STI and health clinics to offer or expand their services to the target population. They will also make sure condoms are available around the areas where sexual contacts often take place.

The project will test innovative interventions that address the whole context and lifestyle of migrant seafarers. For example, because many fishermen cannot send money home and have no

"No matter how we strive to help women develop self-esteem and sexual negotiation skills, they are nevertheless the weaker, non-paying partners in commercial sex."



A group of Kenyan "sand harvesters," the mostly migrant workers who collect sand for cement, watch a demonstration of how to put on a condom.

WENDY STONE/HAISON AGENCY, INC.

safe place to keep it, they are more likely to spend their earnings on alcohol and sex. "We try to help them maximize the benefits of their earnings and increase the communication and contact with families," Dhamarak said.

FHI also plans to provide "predeparture" information to fishermen, who often have unrealistic expectations about the working conditions they will face and the money they can make as undocumented migrant workers.

Ghana Police Service Time away from home and a stressful job also put members of the uniformed services at high risk of HIV. The USAID-funded IMPACT Project is working with the military in Cambodia, Ghana and Nigeria and with the Ghana Police Service to support prevention efforts among these men.

Two years ago, with technical and financial assistance from IMPACT's program in Ghana, the country's national police force began a program aimed at preventing HIV among the police. Lectures on STIs, including HIV, are incorporated into the training curriculum used with police recruits. According to Dr. Godfried Asiamah, a chief superintendent and manager of the Ghana Police Service AIDS Control Programme, "these lectures emphasize safer sexual behavior in order to prevent sexually transmitted diseases, HIV and AIDS, and promote healthy living."

One obstacle the police training program has encountered is police wives questioning the usefulness of condom promotion. "They will ask, 'Are you not promoting promiscuity among our husbands by promoting and providing them with condoms when they go on operations outside their homes?'" Dr. Asiamah reported.

"Police are aware that the duties away from home, night patrols, a high rate of casual sex, unprotected sex, multiple sexual partnership and high alcohol intake common with the police are

risky behaviors," Dr. Asiamah said. Nevertheless, he adds, police service members' perception of their own risk of HIV is low.

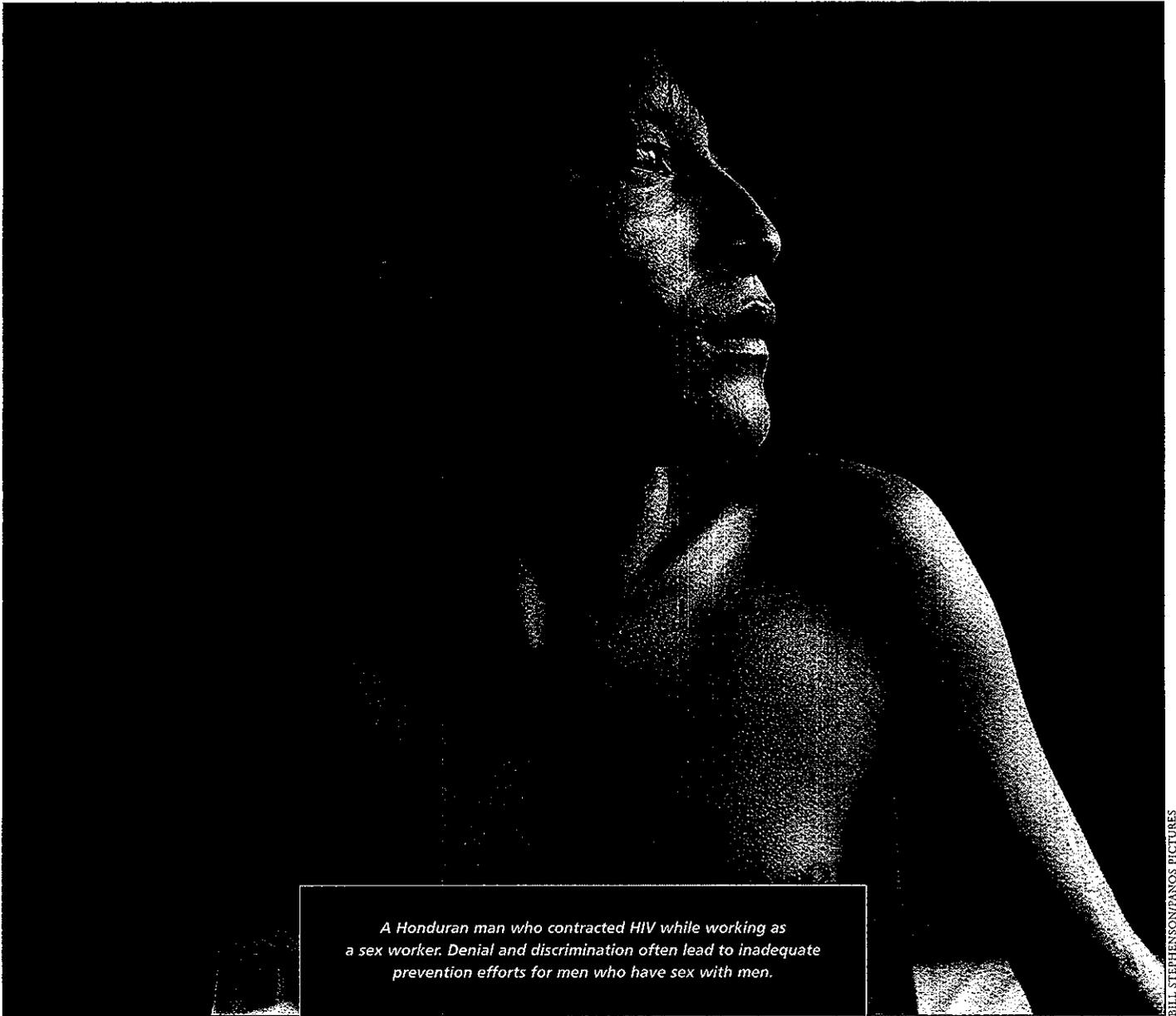
The Ghana Police Service's AIDS Control Programme is targeting about 20,000 policemen, as well as 80,000 of their dependents, including wives, for HIV prevention education and services. To date, 65 peer educators have been trained in three out of Ghana's ten police regions. The program plans to provide every police station and barracks in Ghana with at least one peer educator within the next five years.

Dr. Asiamah believes that peer education works "because peer educators are in continuous dialogue with their colleagues." Such dialogue is necessary, he adds, even though a 1999 survey showed that knowledge of STIs and HIV/AIDS was almost universal among the police. "This knowledge is not committed, as condom use was found to be low and other unsafe sexual practices were common among the police," Dr. Asiamah explained.

Besides education, peer educators offer condoms for sale to the policemen. Experience has shown that condoms distributed freely may not be used. "Policemen attach more importance to condoms if they are acquired with their own money," Dr. Asiamah observed.

The Risks of Secrecy Whether for pleasure, economic reasons, compulsion or a lack of available women, many men have sex with one another despite often-harsh taboos against homosexual behavior in their societies. Surveys suggest that as many as eight in ten men who have sex with men practice anal sex. Unprotected anal intercourse—whether between men or men and women—has the highest level of risk for HIV transmission.

In countries where homosexuality is not accepted, men often hide their sexual orientation by having clandestine encounters or



A Honduran man who contracted HIV while working as a sex worker. Denial and discrimination often lead to inadequate prevention efforts for men who have sex with men.

BILL STEPHENSON/PANOS PICTURES

even ongoing relationships with other men. In these sometimes hurried circumstances, condoms are not likely to be used. Some men, married to women because of social or family expectations, have sex with other men “on the side.”

All-male settings such as the military and prisons tend to increase sexual contact between men. Outside these settings, however, most of the men are likely to have sex with women—increasing the risk of spreading HIV and other STIs to female partners outside the institutions.

Men who have sex with men—whether exclusively or only occasionally—are at heightened risk of contracting HIV and transmitting the virus. Both for the men’s protection and to protect female partners—and, by extension, offspring—HIV prevention targeting men who have sex with other men is essential.

Hostility toward homosexuality has resulted in inadequate HIV prevention efforts in many countries. Some governments have refused to acknowledge that sex between men takes place. Others criminalize anal sex. Many governments refuse to support prevention efforts for men who have sex with men.

As a result, little is known in most non-industrialized countries about the extent of HIV/AIDS among men who have sex with men, the behaviors that put them at risk, or the kinds of HIV prevention services they need. Recent studies sponsored by FHI in

Bangladesh, Cambodia, India and Nepal yielded some answers to these questions that are being used to design HIV/AIDS interventions for men who have sex with men in those countries.

Community Building in Bangladesh The same-sex scene among men in Bangladesh is “distinctive,” says Dr. Carol Jenkins, who was recently an FHI advisor there. In the fundamentalist Islamic area of Sylhet, for example, traditions tacitly permit older men to have sex with younger men because it contributes to the maintenance of female purity.

However, as Dr. Jenkins puts it, “the acceptability is in private—publicly it is deplored.” She noted that a random sample of rickshaw pullers this year in Chittagong, another conservative city in Bangladesh, revealed that 60 percent of the men had engaged in sex with other men in the last year.

Faced with this double standard of private tolerance and public condemnation, FHI is supporting the Bandhu Welfare Society, a local organization that has developed an effective, discreet strategy for reaching men who have sex with men in Bangladesh. “As being a man who has sex with men is a serious source of shame to men if their families find out,” Dr. Jenkins said, “bringing these men together and giving them a safe space in which to discuss their sexual health issues has been extremely valuable and successful.”

Youth Are Most Vulnerable Expectations for how a man "should" behave can take on exaggerated importance for younger men concerned about "measuring up."

Young men in developing countries typically have more sexual partners than older men. They are more likely to inject drugs. But they do not usually see themselves as being at risk for HIV.

The disconnect between young men's behavior and perception of their own risk is apparent in Zambia, for example. There, 64 percent of young men ages 15 to 24 thought they had no risk at all of HIV infection—even though having unprotected sex with multiple partners is relatively common among this age group.

The cultural power differentials between men and women frequently play out between young men and their female partners. These relationships can be exploitative or may involve money or gifts in exchange for sex. They can even be violent. In Southern Africa—South Africa in particular—young men frequently subject their partners to rape and other violence.

Boys and young men in some areas are less likely to know about HIV/AIDS than older men, despite their greater risk. One study of adolescents in Pakistan, for example, found that 25 percent did not know how HIV is spread. Surveys of young men in southern Africa also find them less likely to access medical treatment for STIs.

On the positive side, young men are open to influence, as Martin Foreman notes in a

Panos Institute media briefing on men and HIV/AIDS.¹ "Catching these boys and young men while they are still learning about their bodies and responsibilities to others makes more sense than trying to counter habitual attitudes and patterns of behavior in older adults," Foreman writes.

Opening the Dialogue Jamaican boys are "under a lot of pressure to prove they're a man," says Hally Mahler, an FHI health communication and training officer. "I have some young Jamaican friends who tell me that in high school, boys race their friends to see how many girls they can sleep with. In a year they'll sleep with 40 to 50 girls. It's a manhood ritual."

To educate boys in Jamaica about sexuality and disease prevention requires addressing issues of power and even violence between men and women, Mahler explains. "Girls have little power in Jamaica in negotiating sex, like everywhere else," she said. "Boys are pressured to go out and sow their seed, prove they're not a sissy."

In Rwanda, Mahler has been assisting a youth group associated with the Catholic Church, Jeunesse Ouvrières Chrétienne,

through an IMPACT project that focuses on behavior change. As elsewhere, bringing about changes in behavior requires first changing deeply held attitudes and beliefs.

In Rwanda, a girl is not allowed to consent to sexual relationships. "Even if she wants to have sex," Mahler explained, "she has to say no—and to resist physically."

This means that even sex that might otherwise be consensual plays out as rape. "The sexual power is so skewed," Mahler said. "It's not that boys want to rape girls, but that's the sexual dialogue, and boys feel they have no way around it."

Mahler used a metaphor to help members of the Rwandan youth group challenge some of these assumptions. She asked for a gift, then repeatedly refused it as a colleague continued to press it on her. Finally, as he grew more insistent, she reluctantly accepted the small, gift-wrapped box. This led, somewhat haltingly at first, to a discussion about sending mixed messages with one's body and one's words.

In Jamaica, the same message is addressed more directly. In an exercise that has proved particularly effective, boys and girls exchange gender roles for a day, then talk about the experience.

"In Jamaica we've been doing this gender exchange for some time, and you really see it makes a difference—kids start to respect each other more," Mahler said. "They find that boys and girls really want the same things in terms of respect and communication."

Such realizations are a small step toward an essential shift in the balance of power between men and women. Without strong expectations within their cultures that they will respect themselves and their sex partners (both female and male), men are unlikely to heed messages about condom use and safer sex.

As Mahler points out, "Until you can create an opening in the sexual dialogue, there's no place to start talking about prevention effectively."

Put another way, until men and women alike accept that part of being a man means protecting oneself and one's sexual partners against a deadly virus, HIV will continue to spread.

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Expectations for how a man "should" behave can take on exaggerated importance for younger men concerned about "measuring up."



Hundreds participated in the Phillip Vanderhyden AIDS Walk-a-thon, one of a series of events drawing public attention to the need for HIV prevention in Guyana.

Guyanese NGOs Join Forces to Ready Youth for Healthy Living

BY CHERYL SPRINGER

A project that unites NGOs in the small South American country of Guyana uses music, drama and popular culture to appeal to youth at risk of HIV infection.

The short advertisements first appeared on Guyanese television stations a few weeks before the event. "Teasers," they're called. In these brief TV spots, an attractive girl and a handsome boy pass each other on the street. They eye each other appreciatively. "Mmmm," thinks the girl, "he has a 'ready body.'"

She looks over her shoulder to admire the boy further and finds that he is looking back at her. Both smile. The girl frowns. "But is it really ready?" she wonders to herself. Then words come up on the screen: Do you have questions? Visit the Main Street Fair on August 28, 2000.

Next posters advertising an "Operation Ready Body" event appeared around Georgetown, the capital of the South American nation of Guyana. What was it? No one knew for sure. Because the ads and posters used the popular slang phrase for a good-looking, sexy or well-dressed person, some thought Operation Ready Body might be a beauty pageant, or even a wet T-shirt contest.

Their curiosity—and the driving dance music blaring from enormous speakers—drew hundreds of young people to Georgetown's Main Street August 28. What they found there was a street fair, with booths lining a central block in the capital's main thoroughfare and "Operation Ready Body" banners fluttering overhead.

Far from being disappointed, the young people stayed to enjoy the music spun by disc jockeys and the performances by theater and youth groups. Many stopped at the booths to pick up information about how to take care of their bodies and, in particular, how to protect themselves from sexually transmitted infections (STIs), including HIV. Some pocketed the free condoms that were available at the booths.

As they watched a performance on the stage, one group of young people pronounced the fair, which marked the official launching of the Guyana HIV/AIDS/STI Youth Project, a "brilliant initiative."

(USAID) mission in Guyana in 1998, the agency did not support any health projects in the country. But Dr. Becker, who had served in USAID missions in Asia and Africa, soon recognized that HIV/AIDS was a serious threat to health and development in Guyana.

The proportion of people testing HIV-positive at a given time in surveys among various groups suggests that Guyana's HIV/AIDS epidemic has already moved from those at greatest risk to the rest of the population. For example, 7 percent of women tested for the virus in a 1995 survey at antenatal clinics in Georgetown were HIV-positive.

One prevalence survey found that 45 percent of the sex workers tested in Georgetown—where one out of four Guyanese live—were HIV-positive.

Three to five percent of Guyana's population of 800,000 are believed to be infected with HIV. Among urban, sexually active adults and young people, the level of infection could be much higher.

Most reported AIDS cases are in adults ages 19 to 35, with the greatest concentration among those 25 to 35 years old. Although more cases have been reported among men, the trend in the 1990s was toward an equal number of male and female AIDS cases.

Armed with these alarming statistics and a report documenting limited efforts against HIV and other STIs, Dr. Becker requested additional funds from USAID/Washington to support a "special objective" for HIV/AIDS prevention in Guyana. The amount approved was up to US \$1.1 million over five years, of which \$200,000 was granted for a pilot project in the first year.

Pooling Talents Dr. Becker asked Family Health International's Implementing AIDS Prevention and Care (IMPACT) Project, which is funded by USAID, for assistance in designing the project and providing technical support. Following further consultation with Guyana's Ministry of Health (MOH), USAID decided to support HIV prevention activities by six nongovernmental organi-

The Threat of HIV When Dr. Carol Becker became director of the United States Agency for International Development

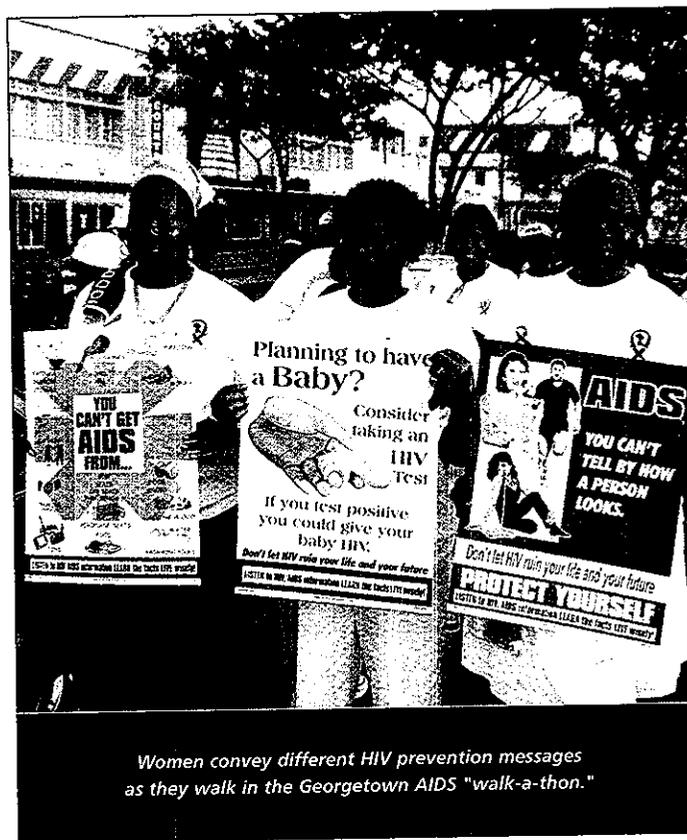
zations (NGOs) from three urban areas. A governmental organization, the Regional AIDS Committee 10 (RAC 10), also expressed interest in collaborating with the NGOs. These groups would work in alliance with the National AIDS Programme Secretariat (NAPS) and the local representatives of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United States Peace Corps.

"With limited funds, it was thought that developing a design that allowed all of the NGOs to work together seemed the most practical approach," explained Carol Larivee, a senior technical officer for the IMPACT Project.

Each of the six NGOs had experience working with youth or in HIV/AIDS prevention, and each brought special skills to the project. Artistes in Direct Support educates people about HIV/AIDS through drama and dance. Comforting Hearts provides care and support to people living with HIV/AIDS. The Guyana Responsible Parenthood Association (GRPA) is the country's main source of family planning and sexual and reproductive health services. Lifeline Counselling Services was established to provide pre- and post-HIV-test and support counseling, but it also runs HIV/AIDS education and training programs. Another group that has broadened its mandate to include HIV prevention education, the Volunteer Youth Corps, was originally formed to offer emotional support to all patients in the Georgetown Public Hospital. Youth Challenge Guyana is the local chapter of Youth Challenge International, which sponsors young volunteers to undertake development work in countries around the world.

Dr. Becker recognized the efforts of each of these NGOs to respond to the epidemic. "But while they were all working towards the same goal, each was operating in isolation," she said. "There was the need to pool their talents, and we hoped that the HIV/AIDS/STI project would act as a catalyst."

Catching the Young The five-year project began with a design workshop in May 2000 that brought together people from all the organizations involved in the Guyana HIV/AIDS/STI Youth Project. It was organized by the Steering Committee, with representatives from the NGOs, RAC-10, USAID, FHI, UNAIDS, NAPS and the Genito-Urinary Medicine (GUM) Clinic, that helps direct project strategies and activities. Along with these groups, other participants represented organizations that collaborate with the project.



Women convey different HIV prevention messages as they walk in the Georgetown AIDS "walk-a-thon."

KENMORE/TABROEK NEWS

The project plan calls for design workshops at the beginning of each of the three phases of the one-year pilot project to ensure that what is learned during one phase is used to improve interventions and strategies for the next.

During the first phase of the project, the NGOs and RAC-10 would assess young people's need for HIV/AIDS and STI prevention education and services and begin to stimulate a dialogue among youth on HIV/STI risk and risk behaviors. The project aims to reach

young people who are not yet sexually active as well as those who are. Lifeline Counselling Services Chairman Dereck Springer explains that defining youth as those 8 to 25 years old "will ensure that we catch the young."

Within that broad age range, the target audiences of young people identified for the project fall into three different groups: "limers," as Guyanese youth who hang out on the street are called, minibus drivers and conductors, and young people in organized groups.

Participants in the first design workshop met in three different groups to develop more complete profiles of the target audiences. Limers, they agreed, like to "hang out" at creek and pool parties, on the sea wall, and at fast food joints and minibus stops. Sex is seen as entertainment. Some limers use drugs and alcohol, have many sex partners, and will have sex in exchange for favors or material items.

Limers and other youth look up to the young men responsible for Guyana's foremost form of public transportation. These drivers and conductors of 12- to 15-seat minibuses are perceived as being macho and "super cool," with lots of spare cash. Workshop participants said that when a minibus driver or conductor becomes infected with an STI for the first time, his friends call it "getting your first stripe." HIV is known as "the Major General," or "the Big Truck."

Workshop participants noted that young people in organizations are a different group from the other two. They are more disciplined and have goals related to their group activities, whether they be athletics or community service. However, they also "lime," or hang out, on occasion, and some are sexually active. They may be misinformed about HIV and STIs and think that they are safe if they have sex only with people in their own groups.

Being "Ready" Workshop participants also divided into groups to begin developing strategies for communicating with members of the three target audiences. It was during this exercise that the theme and slogan "Ready Body—Is It Really Ready?" was born.

The group working on a communication strategy for limers turned to a phrase Guyanese youth have adopted from the dub, rap and reggae music they love: "ready body." Members of the project's Communications Working Group seized on the idea, pretested it with youth from the target audiences, and refined it.

"Ready body is something youth use in Guyana to say it's looking good," explained Desiree Edghill-Adams, a member of the project's Steering Committee and a co-founder of Artistes in Direct Support. "A ready body is cool, dresses well, looks sexy. The main idea was to grab their attention, which we did."

But the project also takes this theme to another level by asking, "Is it really ready?" This question encourages young people to challenge false assumptions about their invulnerability to disease and to assess their risk of STIs and other health threats. Project outreach workers and peer educators will help guide young people through this process and provide the information and referrals to "youth-friendly" services that youth need to become or stay healthy.

Originally the plan was to use the ready body theme only for the first phase of the project. "We were supposed to change the theme, but we haven't because 'ready body' is in the air," said Edghill-Adams. "It has been so popular, we don't want to move away from it just yet."

Youth at Risk The plan developed at the May workshop called for efforts to get young people's attention, culminating in three street fairs in Georgetown, New Amsterdam and Linden at the end of the summer, as well as an assessment of HIV/AIDS and STI prevention needs among the targeted youth.

The Steering Committee hired CESRA Technical Support, a local firm, to develop survey questionnaires and other assessment tools, train NGO members in data collection, and analyze the data. The NGOs worked together to conduct a rapid assessment that included a survey, interviews with health workers and community leaders, and focus group discussions and more informal discussions ("rap sessions") with members of the target audiences.

The thick assessment report paints a grim picture of the risks facing these youth. More than 60 percent are sexually active, and the majority do not use condoms consistently.

Almost half of the youth surveyed said they worried about contracting an STI, indicating that they are probably having unprotected sex with one or more partners.

Perceptions of personal risk of contracting HIV varied among the different groups. Thirty-percent of the minibus drivers and conductors felt that they were greatly at risk of HIV infection, compared to 19 percent of limers and 9 percent of youth in organized groups.

The survey revealed widespread misconceptions about the transmission and prevention of HIV, which were echoed by participants in focus group discussions. Some young people, for example, thought that God would protect them from becoming infected with HIV, regardless of their sexual behavior. Others believed that HIV and other STIs could be contracted from toilet seats, perspiration, sneezing and fingernails.

Prevailing myths about condom use also surfaced during the focus group discussions. Many participants said they don't like to use condoms because they rob sex of its pleasure. Others said using a condom is a waste of time because they don't work.

Some young women had agreed to sex without a condom because they thought they would be raped if they refused. Violence was seen as a threat by an alarming proportion of the young people surveyed. Almost 27 percent said they worried about being sexually abused, and half of them worried about physical abuse.

"What the survey has done is to make us aware of how much at risk our young people are of contracting STIs and the factors which put them at risk," LCS Chairman Dereck Springer said.

The Power of Music The Steering Committee and other project partners started using the assessment results right away at the design workshop for the second phase of the pilot project in September. After reviewing the results and the project's progress, they developed a plan that includes producing communication materials for the project, completing a peer education manual and other training materials, and identifying and training peer educators.

Assessment findings on the judgmental attitudes of many healthcare providers toward young people led to plans for a more detailed study of the available HIV/AIDS and STI services.

Youth-friendly services identified through this assessment will be promoted and strengthened during the third phase of the project, when peer educators will begin to spread the word about HIV/STI prevention to their friends and acquaintances.

The assessment also looked at where young people get their information about sexual health and other health issues and their preferred sources of such information. Based on these findings, the assessment report recommends mounting a sustained and aggressive campaign to dispel myths and promote safer behaviors through music, street theater, disc jockeys (DJs) and popular artists.

The NGOs and others working in HIV/STI prevention in Guyana recognize the power of DJs and popular music. The NAPS, for example, had conducted a workshop with DJs to encourage them to educate young people about how to avoid STIs. The GRPA plans to produce rap messages developed by the DJs and disseminate them on cassettes to minibus drivers and conductors.

Most young people use minibuses. Some refuse to ride minibuses that are not equipped with the large portable radio and cassette players known as "boom boxes," which are illegal but pervasive.

After the Main Street Fair, taped advertisements were distributed to minibus drivers to advertise the street fairs in the two other project areas, New Amsterdam and Linden. As in Georgetown, DJ music drew young people to these fairs and kept them there. However, it also attracted criticism from some adults who thought the music was too loud and went on too long—especially in Linden, where the street fair became a street festival, with people dancing into the night.

Young people's reaction to such criticisms may be some indication of the project's success in reaching its audience. At a forum

organized by Comforting Hearts head Muriel Sandy, the young people asserted that they would not have attended the New Amsterdam fair if there were no music. Nevertheless, they insisted that the fair provided an opportunity for them to learn about protecting themselves from STIs.

"But this has served as a further learning for all of us," said Kenroy Roach, head of Volunteer Youth Corps, of some of the negative reactions to the street fairs. One lesson, for example, is to start events earlier so that they do not become all-night parties.

Building a Foundation Julia Rehwinkel, Peace Corps volunteer and Jack-of-all-trades, is the project coordinator. She acts as the liaison between USAID, FHI/IMPACT and the Steering Committee, coordinates project efforts with regional and international groups, and monitors project activities.

From this vantage point, Rehwinkel has seen a rapid evolution of the relationships among the NGOs and the ways they work together. "At the beginning of the project, each NGO would ask me to arrange any assistance that was required, even if it could be provided by another NGO on the project," she said. "All that has now changed. The group has jelled, and they are now more likely to work directly with each other."

Rehwinkel sees the unity engendered by the work of the Steering Committee as one of the pilot project's most important accomplishments, noting that the groundwork has been laid for the NGOs to continue their collaboration after the five-year project ends.

"I think the consolidation of the framework is a measure of success," agreed Larivee. "This framework, as it is strengthened, should allow for more organizations and donors to participate."

The project recently received its first contribution from a donor other than USAID—\$US 44,000 from Japanese Grant Assistance for Grassroots Projects. The grant will be used to purchase much-needed equipment for the NGO centers.

Moving Ahead In October, the project moved into its second phase. NGO members have begun identifying young people who will be trained as peer educators. The project's Communications Working Group is working with a local consultant to produce a peer education manual and other training materials.

Meanwhile, the NGOs are keeping the Ready Body message in the spotlight. Steering Committee members and project consultants appear frequently on the interview and call-in shows aired by Guyana's 20 TV stations. The combination of many content-hungry TV stations and dynamic, media-savvy promoters has resulted in a great deal of free media coverage for project messages.

The main events of the second phase are the annual Phillip

Vanderhyden AIDS walk-a-thons to raise money for HIV/AIDS care and support. Hundreds of Guyanese joined Minister of Health Dr. Henry Jeffrey at the first walk in Georgetown October 29. DJs wrote safer sex (Ready Body) messages that were chanted along the five-kilometer route.

The NGOs were also gearing up for World AIDS Day, held every year on December 1. Comforting Hearts, for example, was organizing a rally in New Amsterdam for secondary school students. Members of Artistes in Direct Support were working on their annual "The Flame and the Ribbon" program, which drew inspiration from this year's World AIDS Day theme, "Men Make a Difference." Edghill-Adams, who wrote a play for the program, says it opens with a disco scene and the song, "Let's Hear it for the Boys."

Carrying On "The Guyana Youth HIV/AIDS/STI Project is off to an excellent start, but it faces some tough challenges," Dr. Becker noted. These include a dearth of accessible condom outlets, lack of confidentiality in HIV counseling and testing, and little involvement of the Indo-Guyanese population in HIV/STI prevention efforts.

HIV/AIDS is perceived as a problem of the Afro-Guyanese, explains Edghill-Adams. "They think it's a black thing."

This may be because the majority of those who rely on the public health system in urban areas are Afro-Guyanese. Urban-based Indo-Guyanese tend to use the private hospi-

tals and clinics, which do not report on HIV statistics.

Nationwide, the Indo-Guyanese account for 51 percent of population, so it is particularly important for the project to engage them and their religious leaders. The Communications Working Group makes a point of using people of all ethnic backgrounds in its materials. In the Georgetown fair teaser, for example, the girl was Indo-Guyanese and the boy was Afro-Guyanese.

Another major challenge is identifying STI, HIV and other health services that the project can recommend to youth. Without additional funding from other sources, the project will be able to offer only limited training in STI diagnosis and treatment to selected health personnel. Yet the need for high-quality, accessible reproductive health services for youth is great.

The assessment found that more than half of the young people surveyed had sought medical care at public clinics. For STIs, however, two out of three said they would go to a private doctor. Few services, public or private, make youth feel welcome.

Only 18 percent of survey respondents had been tested for HIV. All said that such services should be confidential—a major problem in Guyana, where the stigma associated with HIV is strong.

*Violence was seen as a threat by
an alarming proportion
of the young people surveyed.*

People who test HIV-positive have few places to turn in Guyana. A handful of church groups provide community-based care. Doctors and nurses are often reluctant or unsure of how to treat people living with HIV/AIDS.

Edghill-Adams learned this firsthand when Keith André Sobryan, chairman of the National AIDS Committee and dramatist extraordinaire, fell ill. His doctor was out of town, and she could not find another physician who would come to Sobryan's house. Sobryan died in a private hospital, where his friends took over his daily care because the nurses were afraid to tend to him.

All those involved in the response to HIV/AIDS in Guyana will miss Sobryan, whose candor, talent and insights contributed so much to the fledgling project during its first five months.

While many involved in the project are grieving this loss, they are also inspired to continue the work Sobryan did with such passion and flair. As Edghill-Adams explained, "I am more determined than ever to carry on the legacy he has started."

CHERYL SPRINGER, A GUYANESE JOURNALIST, IS CHIEF SUB-EDITOR OF THE *STABROEK NEWS* IN GEORGETOWN, GUYANA.

Guyana Says Good-bye to "Miss Lottie"

Everyone wore red to André Sobryan's funeral.

It was the way he wanted it, explained Desiree Edghill-Adams, his friend and a co-founder of *Artistes in Direct Support*, a group of performing artists who use their talents to educate the public about HIV/AIDS. "He said, 'When I die, I don't want people to know it's a funeral. I want people to think my funeral is a wedding.'"



André Sobryan

So his friends organized a funeral that was a celebration of the life of Keith André Sobryan, with music, song and laughter. Almost two weeks after his death, virtually every musician, actor and dancer in Guyana performed at a memorial for Sobryan—a fitting tribute to one of Guyana's most gifted artists.

A student of modern and ethnic dance and an accomplished actor and director, Sobryan performed, directed and produced plays, taught acting and dance, and wrote for the *Guyana Review* news magazine. Intensely nationalistic, he represented his country at the annual Caribbean Festival of Creative Arts and introduced North Americans to the Guyanese arts through his performances in the United States and Canada.

In Guyana, Sobryan was a celebrity, known for his larger-than-life personality, his enormous talent, his flamboyant costumes, and his big heart. To some he was best known as "Miss Lottie," the character he created for a Guyana Theatre Guild production called "Ban the Brink, Damn the Brink" in 1979. With her big feet and loud voice, Miss Lottie became a household name, appearing in stage shows, TV programs and advertisements for everything from paint to voter registration.

After Sobryan learned that he was HIV-positive in December 1989, he began lending his talents to the cause of HIV prevention and to fighting the pervasive stigma associated with the virus. In 1993, he helped found *Artistes in Direct Support* to use the arts to convey HIV prevention messages creatively and memorably.

Sobryan pioneered public education about HIV/AIDS in Guyana.

He was also a founding member of the Network of Guyanese Living with HIV/AIDS and the Caribbean Network of People Living with HIV/AIDS.

As director of the National AIDS Committee, which represents NGOs and advises the national AIDS program, and a member of the new Guyana HIV/AIDS/STI Youth Project Steering Committee, Sobryan was a part of almost every HIV/AIDS initiative in Guyana. "All the NGOs in the project

called him for advice," said Edghill-Adams. "He used to be involved in everybody's projects."

Sobryan had returned from the XIIIth International AIDS Conference in Durban, South Africa, where he gave a presentation, and was planning *Artistes in Direct Support's* World AIDS Day show when he became ill in August 2000.

It was his first bout with AIDS-related illness. Sobryan had lived a remarkably healthy 10 years with HIV, even though he never took antiretroviral drugs. He was reluctant to try the potent drug "cocktails" because of their prohibitive cost and because he did not want to "live on tablets."

Sobryan was also troubled by the inequities in access to anti-retrovirals. "He said, 'Why should I benefit from the cocktail when there are so many young people who are beginning their lives who could benefit from it?'" Edghill-Adams remembered.

Nevertheless, as he lay dying in a hospital in Georgetown, Sobryan's friends searched for an affordable source of the medicine that might save his life. They found a group in New York City that was willing to donate the drugs, but it was too late.

André Sobryan died September 11, 2000, with his closest friends at his side. They take comfort in all he was able to accomplish and experience in a life that ended too soon.

"He lived more in 41 years than most men live in a lifetime," Edghill-Adams said.

—Kathleen Henry

FHI PUBLICATIONS

The Family Health International/UNAIDS Best Practices in HIV/AIDS Prevention Collection Family Health International (FHI) and the Joint United Nations Programme on HIV/AIDS (UNAIDS). This book contains 20 case studies chosen by a joint team at FHI and UNAIDS to document and share some of the accomplishments and key lessons from the AIDS Control and Prevention (AIDSCAP) Project. Funded by the United States Agency for International Development, AIDSCAP was implemented by FHI in 50 countries from 1991 to 1997. From decreasing sexual violence against women in Rwandan refugee camps in Tanzania, to increasing access to condoms during political turmoil in Haiti, to salvaging the reproductive health of sex workers through accurate diagnosis and treatment of sexually transmitted infections by chemists in rural Nepal, these case studies report key program innovations launched by AIDSCAP on three continents in the 1990s. They also provide insights into the lessons learned from these experiences that can be applied in other resource-constrained settings to achieve greater impact on HIV epidemics. The book will be published in January 2001.

Behavioral Surveillance Surveys: Guidelines for Repeated Behavioral Surveys in Populations at Risk for HIV These guidelines provide practical information on how to conduct behavioral surveillance surveys (BSS), which are a moni-

toring and evaluation tool designed to track trends in HIV/AIDS-related knowledge, attitudes and behaviors in subpopulations at particular risk of HIV infection. BSS consist of repeated cross-sectional surveys conducted systematically to monitor changes in behaviors that put people at risk of HIV and other sexually transmitted infections. The guidelines cover important topics such as identifying priority subpopulations, developing sampling frameworks and approaches, analyzing data and disseminating results. Sample questionnaires for surveys among youth, adults, female sex workers and injecting drug users are included. An electronic version of the guidelines can be found at <http://www.fhi.org/en/aids/wwdo/wwd12a.html#anchor545312>.

Behavioral Surveillance Surveys Executive Summaries These reports summarize major findings on trends in HIV risk behavior from behavioral surveillance surveys (BSS) in selected countries. Reports are available on BSS results in Bangkok, Thailand (1993-96), Cambodia (1997-99), Côte d'Ivoire (1998), Indonesia (1996-98), Senegal (1997-98) and Tamil Nadu, India (1996-98). Electronic versions can be found online at <http://www.fhi.org/en/aids/wwdo/wwd12a.html#anchor1074959>.

FHI Focus on...Fact Sheet Series Each fact sheet in this series provides an overview of a key topic in HIV/AIDS prevention and care, a description of Family Health International's approach to

interventions in that area, and examples of FHI activities. Fact sheets available in this continuing series cover topics such as FHI's AVERT model for estimating the impact of prevention interventions, behavior change communication, behavioral surveillance surveys, blood safety, evaluation, gender-based interventions, HIV/AIDS care and support, information dissemination initiatives, intervention-linked research, participatory program design, management and prevention of sexually transmitted infections, support for orphans and vulnerable children, TB and HIV, voluntary HIV counseling and testing, and workplace HIV/AIDS programs. Some fact sheets focus on HIV/AIDS interventions for specific populations, such as injecting drug users, men who have sex with men, mobile populations, sex workers and youth.

Ordering Information Single copies of the fact sheets, BSS publications and the best practice case studies are available free of charge. Organizations from industrialized countries are asked to pay shipping charges (please include a DHL, Federal Express or Air Express account number with your request). To order publications, contact Information Programs, Family Health International, HIV/AIDS Prevention and Care Department, 2101 Wilson Boulevard, Suite 700, Arlington, Virginia 22201, USA. Phone: (703) 516-9779 Fax: (703) 516-9781

Meeting the Needs of Young Clients: A Guide to Providing Reproductive Health Services to Adolescents

This handbook for reproductive health service providers, program managers, educators and others who work with adolescents focuses on prevention of unplanned pregnancies and sexually transmitted infections, including HIV. The 100-page handbook contains role-play exercises that providers can use to help young people negotiate condom use and say "no" to sex. Free copies are available to those working in non-industrialized countries.

Reproductive Health of Young Adults: Contraception, Pregnancy and Sexually Transmitted Diseases

Part of Family Health International's Contraceptive Technology Update Series, this slide lecture module on adolescent reproductive health is designed for healthcare providers, program managers and policymakers. It is available in English, French and Spanish. Single copies of the module are free to trainers and educators in non-industrialized countries upon written explanation of need and may be purchased by others. The module is also available online at www.fhi.org/en/ctu/adoltpm/.

Ordering Information

To obtain a copy of the slide lecture module or the adolescent reproductive health manual, contact Family Health International, PO Box 13590, Research Triangle Park, NC 27709, USA. Telephone: (919) 544-7040 Fax: (919) 544-7261 E-mail: publications@fhi.org

OTHER RESOURCES

Open Secret: People Facing Up to HIV and AIDS in Uganda

ActionAid. The authors of this new book in the Strategies for Hope series argue that the reason for Uganda's apparent success in HIV prevention is the openness that has characterized the national response to the epidemic. Their book captures the courage and honesty with which Ugandans in many different walks of life have faced the reality of HIV and overcome stigma and denial. The book, which is number 15 in the Strategies for Hope Series published by ActionAid and distributed by Teaching AIDS at Low Cost (TALC), costs £ 4.50, including postage. Organizations in sub-Saharan Africa that are unable to pay in foreign currency may request up to three copies each, free of charge, of books 8 to 15. Requests for larger quantities will also be considered, on receipt of an explanatory letter. These requests will be considered as long as stocks are available. To order books in the series, write to TALC, PO Box 49, St. Albans, Herts AL1 5TX, United Kingdom, or visit the Strategies for Hope Web site at www.stratshope.org. Tel: (44 1727) 853869 FAX: (44 1727) 846852

Health-Net News-AIDS SATELLIFE. This electronic HIV/AIDS newsletter for health professionals in non-industrialized countries is published twice a month as a supplement to SATELLIFE's weekly *HealthNet News*. It offers summaries of articles, abstracts, full text articles, clinical guidelines and other useful informa-

tion about HIV/AIDS prevention, diagnosis, epidemiology, therapeutics, education and best practices in the response to the epidemic. Research conducted in Africa and published in international medical journals is a key feature of the newsletter. In accordance with SATELLIFE's agreements with medical publishers, subscriptions to *HealthNet News* and *HealthNet News-AIDS* are restricted to health professionals working and living in non-industrialized countries. To subscribe, e-mail autoinfo@usa.healthnet.org.

Facilitating Sustainable

Behaviour Change United Nations Regional Project for Asia and the Pacific on HIV & Development for Asia and the Pacific, the Macfarlane Burnet Centre for Medical Research and the Sydney Myer Fund. This guide suggests issues to consider when designing programs to facilitate behavior change and provides an overview of approaches that have proven to be effective. It draws together theories from various disciplines and life experiences and offers a framework that makes these theories accessible and easily applicable in program design. The guidebook also provides an outline for a workshop, based on the framework, to assist participants in understanding how behavior change may take place in their own settings, designing programs that are relevant in those settings, and conducting participatory evaluations. To request a copy, e-mail Benjamin Brown at benjamin.brown@undp.org or Angeline Ackermans at angeline.ackermans@undp.org.

IMPACT ON HIV

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